

Raro Timu Raro Take Ngāi Tahu Birthing Traditions



Wāhine of Ngāti Irakehu, Banks Peninsula.

Hana Ripeka Tikao (nee Solomon, wife of Teone Taare Tikao is standing on the right) – this is my great grandmother. The others standing from the left are: Tore Teururangi, Kitty Couch (nee Piper), Riti Mapu Manihera (nee Crane) and Lassie Hutana (nee Watson). Seated from left are: Taura Whareuira Tikao (nee Ellison) and Parara Tau (nee Nutira).

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He Whakaihi (Dedication)

This thesis is dedicated to all my tūpuna wāhine. In particular, Hakeke, Rahera Te Hua, Amiria Puhirere, Nohomoke Hokianga, Hana Horomona-Score and Bertha Mata Bunker.

To my mother Kate, who delivered me into this world and who has continued throughout this doctorate to encourage me forward in strength, dignity and love.

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To my participants who allowed me into their lives and to be taken on a wave back in time in order to surge forward. Your sharing and passion for Māori research, inclusive of this kaupapa kept me writing and reflecting on your individual pūrākau. To the midwives who were part of my birthing journey you are part of our whānau whakapapa. You still inspire me today. He mihi anō. To all Māori midwives, and in particular to our Ngāi Tahu midwives, you are inspirational and the future for Māori midwifery, I believe is really exciting.

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To my three sons, Karamuu, Toi and Maio, I want you to know you have a strong place in traditional Māori birthing practices, and alongside your sisters you also carry a role of upholding the teachings of your tūpuna. Your mahi is to protect the mātauranga and reclaim your role as tane and eventual matua in this process. Revitalise our traditions āku tama with aroha and mana. My acknowledgement of my daughters is in the thesis dedication.

To all mentioned and to all who are in my thoughts. The baby has been born after the longest gestation! Done. Thank you for taking this journey with me and struggling alongside me, with me and for me. This hasn't been easy, but like labour I didn't expect it to be, but I did often wonder when, and if, it would ever be over!

My life can embark onto a well needed phase, one of lightness and no more study guilt. And, like all life cycles a chance to begin again...with dignity, respect and gratitude.

Ko te whaea te takere o te waka
Mothers are like the hull of the canoe,
they are the heart of a whānau.

Tuhinga Whakarāpopoto (Abstract)

The restoration of Ngāi Tahu customary birthing rituals and practices may offset the disempowerment and historical trauma this iwi has endured. Colonisation begot greed for land that eventuated in the Crown securing 34.5 million acres of land from Ngāi Tahu which left the iwi essentially landless. The Crown breached the Tiriti o Waitangi by restricting Ngāi Tahu access to their mahinga kai sites and their valued resources. This magnified the injustices that included the loss of political autonomy. Customary rituals and practices were substantially impacted by this history of events including those associated with birth. Assimilation and eventual hospitalisation of birth eroded away the ability for Ngāi Tahu to use their own approaches to health and wellbeing.

This doctoral research sought to discover what remains of Ngāi Tahu customary birthing knowledge and practices, and is it sufficient to empower revitalisation? Will education providers in the Ngāi Tahu takiwā (tribal boundary) prioritise more Ngāi Tahu customary birthing knowledge and practices in midwifery and health programmes?

This doctoral thesis embraced kaupapa Māori as a philosophical foundation and research methodology. A mixed methods qualitative approach examined historical sources, such as archival documents, visual and audio, creation narratives and Māori art. These historical references were triangulated with qualitative individual and group interviews with Māori elders, Māori midwives, Māori midwifery students, midwifery lecturers and Māori artists. Thematic analysis coordinated the amassed data from: interviews, literature and Māori art symbolism into layers of information. The whakapapa of mātauranga gathered in this thesis enabled the richness of customary birthing narratives to be told.

Although our living repositories struggled to recall detail of customary birthing practices and rituals, all has not been lost. This research understood that stored within the land and sea scape, written into the symbolism of Māori art and archived in kawa often expressed at tangihanga awaits the remnants of Ngāi Tahu creation knowledge. The challenge begins on how to best activate and sustain the implementation of this mātauranga Māori. Who will prepare the cultural practitioners to deliver ancestral birthing practices to Ngāi Tahu whānau birthing at home, or in primary and secondary birthing settings?

Growing capacity within the small but eager Māori midwifery workforce to develop their teaching skills and confidence to be midwifery lecturers alongside a focused recruitment of Ngāi Tahu students into midwifery is necessary. Professional development for Ngāi Tahu midwives to learn Ngāi Tahu customary birthing rituals and practices, te reo Māori me tikanga through a series of wānanga and nohonga is also desired. These Ngāi Tahu led measures are essential to best manage the growth of the Ngāi Tahu population, who are young and generative.

In New Zealand there are no kaupapa Māori standalone primary birthing units and too few kaupapa Māori antenatal programmes. This research highlighted the struggle to campaign for customary birthing knowledge and practices to be included into midwifery training and maternity services. Māori health knowledge and practices in mainstream health services and midwifery training appear to be additional. When something is supplementary there is a real risk of it being removed. There may be value in the establishment of independent Kaupapa Māori primary birthing units and antenatal programmes that prioritise and sustain Māori knowledge whilst nurturing culture in whānau. First Nations and Inuit peoples in Canada have already established maternity clinics and antenatal classes in their communities. These clinics are enlivening the integrity of cultural practices amongst the First Nations and Inuit peoples.

It is also key to share customary birthing practices and creation narratives more widely and directly in educational curriculums within the Ngāi Tahu takiwā (tribal area). These avenues capture the ears and minds of young Māori and non-Māori to become champions of traditional knowledge. Teaching others of the existence and importance of this knowledge is how it remains relevant and available to them in their birthing plans when this time comes.

Customary birthing knowledge and practices reinforce whakapapa lines and how critically important the taiao (environment) is for the advancement and wellness of Ngāi Tahu. Restoration of Ngāi Tahu birthing knowledge will have a liberating effect on the life course, cultural identity and wellbeing of Ngāi Tahu whānui. This will contribute towards the reconciliation of the historical trauma inflicted upon Ngāi Tahu whilst simultaneously delivering a vibrant future. Maranga mai, tū tonu, tū tonu Ngāi Tahu e!

Ko te māramatanga o te ingoa tuhinga whakapae (Meaning behind the thesis title)

The title of this thesis is, *Raro Timu Raro Take*. These words are the first two lines of a creation karakia taught to Teone Tikao. He was one of the last Southern tohunga to be taught the ancient knowledge of this region. This creation whakapapa concerns four roots, the third root is *Raro Timu Raro Take*. The word *raro* refers to below in the depths of the sea. The term *timu* describes an ebbing tide and *take* a cause or reason. Tikao described *take* and *timu* as roots situated beneath the sea (Beattie, 1990; Ryan, 1999). This karakia is recited in full on page 36 with a detailed explanation.

Tuhi a tikanga (Orthographic Conventions)

In 2008, I sat next to Christine Rimene at the Ngāi Tahu Hui-a-Tau in Karitane and I was telling her about my next round of academic studies. She said two crucial things at the time that have remained with me for my Masters in Science Communication and my doctorate. The first wise piece of advice was “become a member of the Māori Women’s Welfare League as you will need them for support throughout your research”, and the second thing she stressed was, “do not edit the participant’s kōrero (speak), honour their whole kōrero, give them the space in your thesis to express themselves.”

Consequently, I joined the Rapaki Women’s Welfare League and I have quoted and kept the kōrero from my participants to their spoken words. Christine’s advice was about maintaining integrity and honour. If only I could include all of the pūrākau shared with me during this journey, but keeping it to this body of knowledge was challenging as it was.

I have added the translation of the Māori words immediately following in parenthesis and I have also included a glossary of Māori words at the back of this thesis. I have applied macrons over the pronounced double vowels for Māori words and not the double vowel option. However, if an author has used neither I have followed their lead when it comes to quotes or literature titles.

I have used the Ngāi Tahu dialect when it is used in quotes from my research participants or in a literature title. I have also used it in Ngāi Tahu creation stories when it is expressed this way in the literature. I have kept with the “ng” in words rather than using the Ngāi Tahu “k”, however, certain words reserved the “k” if taken from participant quotes or were referenced from the literature.

Tuhinga o mua (Table of Content)

Dedication	ii
Acknowledgements	iii
Abstract	vii
Meaning Behind the Thesis Title	xi
Orthographic Conventions	x
Table of Contents	xi
List of Illustrations	xiv
Unutai au?	1
Chapter One - Te Whe / Introduction	2
Chapter Two - Te Pō – Ko Uatipu / (Creation) / Literature Review	15
2.1 Section One - The Power of Birth	17
2.2 Section Two - The Ngāi Tahu Creation Narrative	33
2.3 Section Three - Te Iwi o Ngāi Tahu	45
Chapter Three - Whakatō Tamariki (Conception) / Methodology	75
3.1 Section One - Kaupapa Māori Theory and Methodology	78
3.2 Section Two - Methods employed in this research	100
3.3 Section Three - Analytical Approach	117
Chapter Four - Hapūtanga (Pregnancy) / Colonisation – The effects of laws and policies on Ngāi Tahu	120
4.1 Section One - Influences on the health of Ngāi Tahu	123
4.2 Section Two - Addressing Māori Health	149

4.3 Section Three - Initiating for Māori by Māori from 1920	158
Chapter Five - Whakamamae (Labour) / Māori in Midwifery	170
5.1 Section One - Māori Midwifery Today	172
5.2 Section Two - Midwifery Education	200
Chapter Six - Whānau Mai (Birth) / Ngāi Tahu birthing traditions and midwifery health practitioners	230
6.1 Section One - The Conveyance of maternity knowledge through rituals	235
6.2 Section Two - Waiata and Oriori	247
6.3 Section Three - Toi Māori	261
6.4 Section Four - Tikanga, Hapūtanga me Whānau mai	273
6.5 Section Five - Ngāi Tahu Kaiwhakawhānau	288
Chapter Seven - Pēpitanga (the newborn)/An Indigenous Comparative Review	296
7.1 Section One - First Nations and Inuit Peoples of Canada	300
Chapter Eight - Hākari (the feast) / Discussion and Conclusion	346
8.1 Section One - Holding onto ancestral knowledge	351
8.2 Section Two - The degenerative outcome of cultural suppression	355
8.3 Section Three - Mana wāhine, Mana reo	361
8.4 Section Four - Colonial Legacies and the challenge to Ngāi Tahu Birthing knowledge	368
8.5 Section Five - Revitalising Ngāi Tahu Birthing Practices	371
8.6 Section Six - E Tipu E Rea – Scaffolding Solutions	377
8.7 Section Seven - The learning along the way	385
8.8 Section Eight – Karawhuia (Let's do it) and Conclusion	391
9. Karakia Mūtunga	394

10. Appendices	395
10.1 Appendix A:	397
(i) University of Canterbury Ethics Committee Approval	
(ii) Māori Advisory Group Consultation	
Response Letter	
10.2 Appendix B:	404
(i) Participant Information Sheet	
(ii) Participant Consent Form	
10.3 Appendix C:	407
(i) MScicomm student film, <i>Iho a cord between two worlds</i>	
(ii) Presentation Opener	
(iii) Presentation Closer	
10.4 Appendix D:	408
(i) Research Questions	
11. Glossary	412
12. References	421

Rārangi Whakāhuatanga

(List of Illustrations)

Figure 1	Artist Piri Cowie “Pēpi and Iho” 2011	Page 2
Figure 2	Map of Ngāi Tahu Land Purchases 1844-1864	Page 65
Figure 3	Promotional research business card/poster	Page 107
Figure 4	Te Puawaitanga ki Ōtautahi Trust Kaupapa Māori Antenatal Promotional Poster	Page 188
Figure 5	Tanewha Rock Art from the Opihi River. National Art Gallery Collection	Page 262
Figure 6	Rock art figure carrying a pole and bag located in South Canterbury.	Page 263
Figure 7	Pencil sketch of single and double hulled waka	Page 265
Figure 8	Tauihu from Masons Bay, Stewart Island displayed at the Southland Museum and Art Gallery.	Page 266
Figure 9	Whakairo pattern. An example of a raperape design	Page 267
Figure 10	Whakairo pattern. An example of the taratara-a-kai design	Page 267
Figure 11	Tauihu drawing over image displayed at Toitu Museum	Page 267
Figure 12	Pītau– fern frond	Page 272
Figure 13	Koru spiral in a kōwhaiwahi pattern	Page 272
Figure 14	Provinces and Territories of Canada	Page 301
Figure 15	Inuit Population by Residence 2016	Page 302
Figure 16	Onepū Performance A - Wind Goddesses	Page 362
Figure 17	Onepū Performance B - Atua Wāhine	Page 363

Unutai au?

No hea ahau?

Ko Aoraki te maunga

Ko Waimakariri tōku awa

Ko Uruao, ko Takitimu ōku waka

Ko Waitaha, Ngāti Māmoe, Ngāi Tahu ōku iwi

Ko Tauponui, Tura, Rongokako, Uenuku, Ngāti Irakehu, Ngāi Tarewa, Ngāti Kahukura, Ngāti Hine Kura, Ngāti Urihia, Ngāi Tūhaitara, Ngāi Tūāhuriri, Ngāti Wheke ōku hapū

Ko Ōnuku, Ko Koukourarata, Ko Rāpaki, Ko Tūāhiwi, Ko Wairewa, Ko Waihao, Ko Taumutu, Ko Takahanga ōku Marae

Ko Tikao, Ko Bunker, Ko Hokianga, Ko Te Atahau ngā ingoa whānau

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Ko Karamū, Ko Wairāmia, Ko Hinekaea, Ko Toi, Ko Maio āku tamariki.

Ko rātou, Ko au, Ko au, Ko rātou.

I write this thesis as a Ngāi Tahu mother and researcher who is very much a student of the world. I see every component of my doctorate through a mothers' lens that is prompted by my birthing experiences: at home, in the hospital, in water, on the land and amongst whānau and the wonderful care of my midwives.



1

Fig 1. Piri Cowie Pēpi me tōna iho, 2011

Ko te Tīmatatanga Kōrero (Introduction) Te Whe

Raro timu, Raro take, Raro pou iho, Raro pou ake...

When I began this kaupapa (topic), it was like reciting a pūrākau (story) with no beginning, just a middle and an end. When a culture has forgotten its customary birthing practices, I believe a crucial part of the whānau (family) and a child's pūrākau or life story is missing. Rituals and customary maternity practices provide many platforms for imparting a child's story before they are born (Pereme, 2011; Tau, 2003; Tau & Waruwarutu, 2011). It intrigued me when an elder from my hapū (kin group) highlighted how birthing rituals are now almost non-existent, yet our tangihanga (death) rituals still proceed (Moorfield, 2011; Tikao, 2013). It left an impression that the focus for Ngāi Tahu is now weighted more strongly towards the reality of death than the phenomenon of birth. If we have lost the art of conveying knowledge, whakapapa (genealogy), and history via customary childbirth rituals and practices, how well are we preparing our whānau and tamariki (children) for their life's journey? It was this broad question that provoked me to undertake this doctoral research.

The discovery that this kaupapa is not easily detected in the literature did not deter me from pursuing it. On the contrary, I was more determined to find out what I could,

where I could. I was intrigued as to why social and domestic lifestyles of Māori were not discussed in greater magnitude in literature. Knowledge about childbirth is rarely indexed and when I did find an index listing, the information provided was but a fragment of another discussion. However, after many library visits and reading a voluminous quantity of literature, I was able to gather enough strands of information to aid the telling of this story.

This thesis aims to contribute to awareness of the gaps in knowledge and to highlight what *is* known about customary birthing practices and how this can apply to modern Ngāi Tahu birthing plans. Whakapapa (family lineage) is the pivotal point of this thesis, as it is ancestral knowledge that literally and spiritually comes into action when birthing using customary birthing rituals and practices. Cultural birthing practices align whakapapa and the mechanics of birth as one, using ancient wisdom, values, rongoā Māori and customary birthing rituals.

As discussed by Barker (2010, 2016), Pocock (2000), Short (2005), Smith (2003), Walker (1990) and Ward (1996); the topics of colonial settlement, land loss, assimilation, the effects of introduced diseases on Indigenous peoples, and political disempowerment provide the broad contextual backbone as to why Māori remain in a state of cultural and economic loss today. The engagements between the colonial settler state and Māori, which have underpinned the struggles within Māori communities, have dominated our cultural narrative since the mid-19th century. This thesis discusses the impacts of colonisation, urbanisation and government policy specifically on te iwi o Ngāi Tahu (the people of Ngai Tahu) in order to understand why customary birthing practices and rituals have become compromised and undermined, if not also completely lost, from the daily lives of Ngāi Tahu.

Ngāi Tahu worldviews and practices have continued to be emasculated by policies and practices that serve as barriers to education and health, as demonstrated most notably through midwifery training. Cumulatively, we have seen the erosion of knowledge and autonomy in the maternity sector. With this awareness of knowledge loss in collaboration with knowledge reinvigoration, several other inquiries beckon:

1. What is known about Ngāi Tahu customary knowledge and practices and do they remain applicable?

2. What was the contextual landscape in the history of Ngāi Tahu that contributed to the decline in customary child birthing practices?
3. What will be required in terms of knowledge acquisition and capacity building in the restoration of these practices?
4. What can be learned from a comparative review of the First Nations and Inuit people's reclamation of customary birthing practices in Canada, that can aid a similar return for birthing knowledge and practices for Ngāi Tahu?
5. Would the establishment of a stand-alone kaupapa Māori birthing unit be a beneficial consideration?
6. Can more Ngāi Tahu birthing knowledge and practices be incorporated into the midwifery curriculum of the two South Island Bachelor of Midwifery providers?
7. How can more Ngāi Tahu be lured into the midwifery profession?

Henry and Pene (2001) state that kaupapa Māori epistemology sits within Māori cosmology. Kaupapa Māori research acknowledges and gives voice to Māori epistemology. This ensures Ngāi Māori (Māori tribes) speak their past to ignite ancestral knowledge. Kaupapa Māori research assists the fusing of prior wisdom with contemporary culture and technology evolution. Dame Mira Szaszy aptly captured the above sentiment as the first secretary and past president of the Māori Women's Welfare League when she incited Māori to "build a vision for the future founded on a new humanism, a humanism based on ancient values but versed in contemporary idiom" (Henry & Pene, 2001, p. 238).

Traditional Māori birthing practices offer an insight into how Māori once lived, survived, and perceived their world. I believe ancestral knowledge remains relevant in this evolving world and transgresses time. I also believe that customary practices play an essential role in the wellbeing of Māori today; connecting them to this knowledge will be the conduit between this thesis and my work as a health practitioner. This

research project was conceived within my own birthing narrative, so to explain my position within this project is to provide a brief explanation of how I arrived at this thesis.

Firstly, I need to place a disclaimer that I am not a midwife. From the poignant moment when I observed the homebirth of my cousin's little girl, who is now 21 years of age, I became invested in the exploration of traditional Māori birthing practices. I am, however, a senior registered nurse, a Māori researcher, a broadcaster, an art enthusiast and, first and foremost, a whaea (mother). I have worked in health for over 20 years in different settings and with various specialties. It is from being a whaea and a kaihauora (nurse) that I feel at ease to commence this work. I also believe that I do not have ownership over this work. I have completed this work alongside other hākui, whaea, māmā, kaumātua and Māori midwives that have shared their stories – tātou, tātou.

I had my first child in 2001 and I wanted a Māori midwife to help me learn about traditional Māori birthing practices. I called upon Derna Trifilo, a Māori midwife, and I will never forget the sense of wonderment and fear when she asked me if I was considering having my baby in the bush, by the sea, at the Marae or outside at home? This was beyond what I had naively interpreted Māori birthing practices to be. Our time together was unfortunately brief, as Derna found out she was hapū, due the same time as me and was considering shifting to Australia. Very good reasons for me to look for another Māori midwife. However, I never did find another Derna Trifilo for my next four births. I found some incredible midwives who I mihi to for how they contributed towards the births of my babies, but the journey is far from easy when it comes to wanting to use your own cultural traditions. There were too few Māori midwives and even fewer who felt confident to implement Māori customary birthing practices.

I used a number of traditional Māori birthing practices in each of my births, such as: karakia (incantations); waiata (songs); hinu (oils) on my puku (belly); I did not cut my hair throughout the pregnancy; I used whītau muka (cordage to tie the umbilical cord) and I used a pounamu maripi (greenstone knife) to cut the cord. I made my own ipu whenua (natural placenta container) out of pumice, clay, taha (a gourd) and harakeke (flax) and buried the whenua (placenta) into the whenua (earth). I buried the pito (dried end of the umbilical cord by the naval of the baby) in the grounds of my babies other Marae. We named our babies after names in our whakapapa (family genealogy); we

had a kaumātua (Māori elder) bless us and our newborn and we had a waiata composed for our mātāmua (eldest). My partner did karakia to welcome our tamariki (children) into the world, and we had three of the five at home surrounded by whānau (family) across the generations.

We learnt as we went, and we became more confident with the natural tools. We worked as a team with our midwives; they shared their midwifery skills and we shared what we had learnt about traditional Māori birthing practices. We respected each other's mohiotanga (knowing) and we valued the collaboration and trust.

I completed a Master of Science Communication at the University of Otago and I based my thesis research and film on traditional Māori birthing practices. For the seven years since the completion of this student film it has been requested and duplicated copious times. The demand for this 25-minute student film stressed the lack of Māori resources on this kaupapa. It also highlighted the interest in what traditional Māori birthing practices are and how whānau can incorporate them into their own birthing experience. This doctoral study was undertaken to delve further into this kaupapa from a Ngāi Tahu perspective by shedding light on the mana of birth.

A kaupapa Māori approach was the most appropriate thesis framework for this kaupapa. I have not followed a traditional health science doctoral process that works towards a results chapter but have incorporated the results and knowledge throughout the thesis chapters. Chapter Five perhaps has the strongest lean towards findings but not entirely. This adherence to kaupapa Māori has been endorsed by my kaumātua rūpū tautoko, who reiterate that compartmentalising mātauranga Māori heightens the risk of presenting the knowledge minus its wairua (spirit). Instead, this thesis weaves the feedback from all sources undertaken to find the knowledge throughout. I liken this process to weaving a whāriki (mat) or telling a pūrākau, that then can be seen, in terms of a whāriki, and heard, in terms of a pūrākau, when the weaver or storyteller indicates completion (Pere, 1982; Smith, 1999; Valentine, 2009; Valentine et al., 2017).

I have used a hapūtanga framework to structure this thesis. Hapū is to be pregnant or a term for sub-tribe and the tanga is a suffix used to turn the word from a verb to a noun. Hapūtanga encompasses the entire pregnancy. It is a natural metaphor for progression, development and outcome or a relationship, conception, gestation and birth. Hapūtanga

encases this thesis from the period of forming a relationship, feeling the passion, to the inkling of potential and the formation of body, mind and soul and then birth.

The thesis framework will be presented as follows:

Chapter Two – Te Pō – Ko Uatipu: Literature Review

In the vast eons of time that preceded the universe's conception, were Te Kore (the void) and Te Pō (the darkness or night). Their sequential presence enveloped the potential of the world that was soon to be born (Beattie, 1990; Marsden, 2003). A creation karakia (incantation) recites the layers of whakapapa (genealogy) that illustrate life's order. Every word prepares the woman's whare tāngata (house of people/womb/uterus) as if laying a metaphoric whāriki (mat) down in preparation for what is to come (Beattie, 1990; Marsden, 1992, 2003; Tiramorehu, 1987). *Te Pō – Ko Uatipu* houses the literature review and provides the foundation on which the thesis is built.

The literature review adopts a two-pronged inquiry: it attends to what is known about this particular subject, and it then discusses the historical context for Ngāi Tahu that led to the loss of their customary birthing practices. The origin of birth pūrākau (stories) through mythology is addressed, which is concerned with the very beginning of creation itself. Mythology provides a repository of ageless knowledge and sacred lore that was shared with all through the talents of storytellers or illustrated in ritualistic incantations and tribal chants.

The second section of this chapter examines Ngāi Tahu creation narratives and the moral messages embedded within these pūrākau (Thornton, 2004; Walker, 1978). After the uprising of Papatūānuku (Earth Mother) and Ranginui (Sky Father), the birth of humankind followed.

The chapter then moves to an overview of how te iwi o Ngāi Tahu (the Ngāi Tahu tribe) migrated to Te Waipounamu (the South Island). It then discusses the pivotal historical events that shaped this iwi, such as: tribal feuds; the arrival of whalers and sealers; their trading economy; Te Tiriti o Waitangi (the Treaty of Waitangi); and the land transactions that led to years of Ngāi Tahu seeking justice and restitution for broken Te Tiriti o Waitangi promises (Anderson & Tau, 2008; Evison, 1998; O'Regan, 2014, 2017). The purpose of this section is to examine the significant political, legal, and economic influences that shaped the world of Ngāi Tahu, including their capacity to retain and hold their customary knowledge systems.

The literature review offers a scoping process of what can be identified in the literature about my kaupapa (thesis topic) and what knowledge had been lost or not recorded in a written form. This body of work prompted a broadening of the search to consider other knowledge repositories, including oratory and Māori art mediums to collectively tell this part of the Ngāi Tahu birthing story.

Chapter Three – Whakatō Tamariki (Conception): Methodology

Chapter three outlines the methodology used to gather data and the philosophical underpinnings of this thesis. The word whakatō used in the title of this chapter means to conceive or drag, and the word tamariki refers to children. The methodologies employed in this research are the tools that enable ideas to be conceived and brought into fruition or made sense of, as in whakatō. The methodology, therefore, begins with a conception of a whakāro (idea) or seed, which is planted or gestated to become its own entity or kaupapa (topic/subject). The rauemi (tools/resources) used to assist the moulding and development of the kaupapa can be likened to the methods applied in research.

More specifically, this chapter discusses the approaches and strategies used to recruit the research participants, to record their stories, and to access all other knowledge sources. Kaupapa Māori theory and seven kaupapa Māori research principles guided

this study: Tino Rangatiratanga (the principle of autonomy); Taonga Tuku Iho (the principle of ambition and goals); Ako Māori (the principle of learning and teaching); Ka pike ake i ngā raruraru o te kainga (the principle of negotiating improved social and economies of finance for the whānau (family); Kaupapa (the principle of a collective understanding and appreciation); Te Tiriti o Waitangi (the principle of a Treaty between Māori and the Crown); and the final principle, Ata – to ensure, as a researcher, I treat the kaupapa and those who take part in this research with the utmost respect (Bishop, 1996; Jenkins, 2001; Pihama, 2001; Pohatu, 2005; Smith, C., 2002; Smith, G., 1990, Smith, L., 1997).

Mixed-methods (Denzin & Lincoln, 2008; Morse, 2009) were employed in this study and included: semi-structured qualitative interviews; two workshops held at two Ngāi Tahu marae; audio, visual and literature archival sources; and the analysis of symbolism crafted into Māori art forms, such as whakairo (carving), raranga (weaving), kōwhaiwhai (rafter painting) and toi ana (cave art/rock drawings). Braun and Clarke's (2006, 2013) approach to thematic analysis was applied to the data to find common ideas that contributed to the overall research intent. This chapter also describes the strengths and limitations that transpired, particularly in light of the diverse data sources that informed the thesis.

Chapter Four – Hapūtanga: Colonisation – The effects of laws and policies on Ngāi Tahu

The fourth chapter, *Hapūtanga*, reflects the gestational period and growth of the child in utero. This chapter examines the historical health setting for Ngāi Tahu between the nineteenth to the twentieth century. It specifically highlights key events and legislation that had consequences for Ngāi Tahu that directly and indirectly removed customary birthing practices and rituals from their lives.

The “land grab” by the Crown, missionaries and the New Zealand Company to meet the influx of settlers in Aotearoa (New Zealand) had dire consequences for Ngāi Tahu. This included reserves not being allocated to Ngāi Tahu as promised in the land purchase deeds by the Crown representatives. Colonial policies also resulted in lands being set aside for Ngāi Tahu that were not viable for cultivation or that were situated in challenging locations (Anderson, 1990; Evison, 1988; Tau, 2013). Ngāi Tahu suffered limited access to their traditional food sources post the signing of Te Tiriti o

Waitangi in 1840. The dire state of affairs saw Ngāi Tahu challenging the government over many years to deliver on their promises of providing schools and hospitals (AJHR, 1868, A-6; AJHR, 1885, G2a; AJHR, 1889, I-10; AJHR, 1904, H-31, O'Regan, 2017; Tau, 2017; Waitangi Tribunal, 1991, 1995).

I also include in this chapter broader national level policies and programmes that have influenced Ngāi Tahu worldviews and practices, especially as they relate to birthing. I examine legislation, including that led by Māori politicians to protect Māori, such as the Tohunga Suppression Act of 1907. This statute resulted in removing the swindlers parading as tohunga (expert practitioners), but it also reduced access to ancient knowledge that informed practice and rituals by making it illegal to be a tohunga (AJHR, 1906, H-31). As time progressed to the late nineteenth century, health services evolved from Native Schools playing their role with basic health assessments and the dispensing of medications to the establishment of the Division of Māori Hygiene in the Department of Health in the 1900s to address sanitation (AJHR, 1880, H-1F; AJHR, 1905, E-02; Bryder & Dow, 2001). Māori councils and native health inspectors were employed to carry out assessments and regulate approved health and sanitation standards within Māori settlements. The introduction of the Māori nursing schemes was designed to attract Māori girls to work within their communities (Dow, 1995; Bryder & Dow, 2001; Lange, 1999; Ramsden, 1990). From the 1920s, Māori health organisations, such as the Women's Health League in 1936 and the Māori Women's Welfare League in 1951, enlisted the support and interest of Māori women all over the country to focus on improving the health of the whānau. My interest in these Māori institutions was to determine whether they placed any focus on retrieving Māori customary birthing practices and rituals.

Chapter Five – Whakamāmāe: Māori and midwifery

The fifth chapter is positioned within the gritty stages of labour. This is called *Whakamāmāe* (feel pain) with the subtitle of *Māori midwifery today*. It examines the journey from the nineteenth century to the present and explores impacts on spiritual and physical realms. It is not ironic that this segment of my thesis examines the challenges facing maternity services and midwifery tertiary education providers to increase Māori customary birthing knowledge into midwifery practice. Inclusive of luring Māori staff and students into the midwifery degree programme.

The first section of chapter five provides an overview of midwifery and Māori inclusion into this mahi (work) before addressing the reality for Ngāi Tahu in terms of planning for the growth in population and their rising fertility rates.

This chapter also examines the disjuncture between the growing Ngāi Tahu population and modest number of 23 Māori midwives in the region with current practicing certificates. This cohort struggles to meet the maternity needs of the Christchurch community, which also has the highest rate of whānau Māori birthing statistics in Te Waipounamu (Midwifery Council of New Zealand, 2016).

In addition, the chapter explores what support is available for the midwifery workforce. Alongside Ngā Maia o Aotearoa (the National Māori Midwifery Collective), the Canterbury Midwifery Rōpū (Christchurch support and networking group for Māori midwives) strive to develop incentives to encourage more Māori into midwifery by offering mentoring support through to completion of their studies. The Canterbury Midwifery Rōpū also works with Māori midwives with whakawhanaungatanga (networking) and professional development to ensure they grow stronger in their skillset and are supported as wāhine Māori in midwifery (J. Te Huia, Ngāti Kahungunu; Māori midwife; R. Chisolm, Ngāti Porou, Māori midwife).

Chapter Six – Whānau Mai: Ngāi Tahu birthing traditions and midwifery health practitioners

The preparation in previous chapters eventuates in birth. Thereby, chapter six is aptly titled, *Whānau Mai*. This chapter examines Ngāi Tahu birthing traditions and memories of Māori lay midwives. Having laid down a metaphorical whāriki (mat) of context with the previous chapters, it is appropriate to then address some of the customary birthing practices and rituals of Ngāi Tahu that have been remembered by the research participants and gleaned from other knowledge repositories.

Ngāi Tahu elders, Matiaha Tiramorehu and Teone Tikao, were taught creation karakia (incantations) and waiata (songs) that they passed onto their whānau and hapū. Other karakia and waiata explicitly used for preparing a wāhine to conceive, to be recited during hapūtanga (pregnancy) and at the birth were also accessed from manuscripts. These karakia were often not easy to find as they were dispersed amongst other tribal kaupapa. These specific rauemi (resources) carried whakapapa history and significant

events that were considered essential to retain in mediums, such as karakia and waiata that would be repeated and therefore remembered (Tiramorehu, 1987; Beatties, 1990). Apirana Ngata and Pei te Huri Nui Jones collated and translated hundreds of iwi waiata (tribal songs) in the Ngā Moteatea series (1972). Examples were given in the series of oriori (lullabies) sung during hapūtanga to inform the developing foetus of their whakapapa and to soothe the pēpi (baby) once born (Reedy, 2008). From examining the use of waiata as a transmitter of knowledge and rongoā (Māori healing), this chapter then addressed knowledge deposited in Māori art symbolism (Beattie, 1990, 1994; Cameron, 2011; King, 1992; Tikao, 2013; White, 1887).

The final section is a tribute to Māori midwives who are remembered by their descendants for their commitment to many whānau of the kaik (village) and surrounding areas. These midwives, of both sexes, were the Māori pioneers of public health care. They knew their hapori (community) well and welcomed many generations into the world. They also carried tribal knowledge and rituals pertaining to birth and trained to continue this work. Early midwives were not known by their vocational title, but by their skills and the wisdom they possessed. It was not uncommon that those who assisted with the birthing of babies also carried the skills to prepare the dead for tangihanga (funeral) (R. Pitama, Ngāi Tahu; McClean, 2013). These early practitioners mastered the attributes that nurtured whānau both physically and spiritually when entering the dominion of light and departing to the realm of Hine-nui-te-Pō (goddess of death) (Beattie, 1990).

Chapter Seven – Pēpitanga: An Indigenous comparative review

This chapter is titled, *Pēpitanga*. The pēpi (baby) has arrived, and it is time to reflect upon the gestation journey and to introduce the pēpi to the broader society; the broader society being in this chapter, other Indigenous collectives that appear to be on a similar trajectory as Ngāi Tahu.

Following kaupapa Māori tikanga, it is tika (correct) in a formal setting to begin with mana tāngata (home people) welcoming and establishing the kaupapa (purpose of the gathering) and once the mana tāngata have completed this part of the process, they then hand the rākau kōrero (opportunity to speak or be included) to the manuhiri (visitors). When the manuhiri have completed their introductions and shared information, tikanga Māori then dictates that the rākau kōrero is handed back to the mana whenua to place a

closing on the proceedings and move into a state of noa (ordinary), from the formal to the informal. Metaphorically, the placing of this chapter at this stage of the thesis is to honour this kaupapa Māori process before it comes back to the mana whenua with the conclusion (Marsden, 1992; Mead, 2003; K. Tirikatene, Ngāi Tahu, kaumātua).

This chapter is an Indigenous comparative review of the First Nations and Inuit peoples. These specific Indigenous identities have been chosen because of their maternity leaders who have expressed their views on the importance of revitalising their cultural birthing practices (Balkinsoon, 2018; Cook, 2003; Gonzales, 2012). *Pēpitanga* essentially asked, what can be learnt from other Indigenous communities to aid Ngāi Tahu knowledge retrieval?

This Indigenous comparative review begins with backgrounding the First Nations and Inuit peoples to ascertain population demographics and cultural values in terms of their Indigenous customary birthing practices. Key statutes are highlighted that have historically shaped the outcomes and identity of the First Nations and Inuit peoples. The latter part of chapter seven considers the birthing rituals and practices of these Indigenous collectives (Cresson, 1938; Garcia-Hernandez et al., 2015; Poma, 1987). The training of Indigenous midwives, the role of government health initiatives and policies, such as community nursing stations are discussed in terms of their benefits and costs. Challenges relating to the inclusion of customary birthing knowledge into mainstream midwifery training in Canada conclude this chapter.

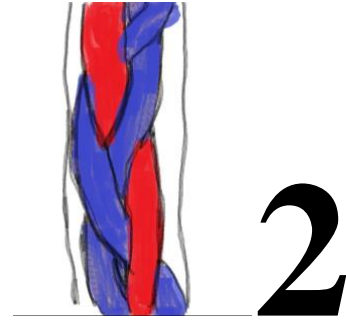
Chapter Eight – Hākari - Ko te Matapaki Kōrero (Discussion) me te Whakamutunga (Conclusion)

The final section of the thesis is the Hākari (the feast) and a gathering of all to celebrate the whānau and the newborn. The intention of the hākari is to remove the tapu (sacredness) from the birth and return the mother, whānau, and the place of birth to a state of noa (ordinary, not sacred). Cooked food serves as a tool to neutralise the tapu, therefore eating together brought a spiritual and physical closure to the birthing journey (Marsden, 1992; Manihera et al., 1992). This section discusses in detail the research findings and concluding themes, and the strengths and limitations of the study. This includes future plans to disseminate the findings and the development of maternity resources for Ngāi Tahu whānui.

I have included in the Appendices links to film clips presented at doctoral addresses throughout this research journey. They were created to illustrate examples of practices and rituals in the past and contemporary context. I have included a short student documentary film, “Iho- a cord between two worlds” produced for my Master’s degree on traditional Māori birthing practices. These visual vignettes are located in Appendix C, as follows

- Iho – cord between two worlds (documentary on Traditional Māori Birthing Practices).
- Presentation Opener - Oriori example and cutting the cord.
- Presentation Closer - Creation karakia sung by Ariana Tikao and images.

The last voice in this thesis is given to a creation karakia (incantation) that enfolds the essence of this doctoral thesis. Therefore, using the analogy of a life cycle, where one life concludes, and another commences. We begin the second chapter with the scoping of literature related to this kaupapa that will then set the scene for the subsequent chapters. Ka tīmata (let’s begin)...



Te Pō – Ko Uatipu / Literature Review

Ko Takū, Ko Takeo, Io io whenua...

Ko te Tīmatatanga (Introduction)

It became evident at the beginning of this doctoral journey that to understand Ngāi Tahu birthing practices was to understand how Ngāi Tahu might have perceived the ultimate birth – that of the Universe. Tracing this particular knowledge about Ngāi Tahu required exploring creation mythology, teasing threads from their mythical stories and unraveling them to discover how Ngāi Tahu believed the Universe came into being, including the origin of humans.

Therefore, the first section of this chapter is about mythology and the purpose of mythical stories as knowledge holders, value installers, and a tool of research ethnography. Tribal myths carry important beliefs and warnings in order to keep people safe. Survival of people is paramount; mythical stories cross the threshold of past and present. They are able to tell of something significant in the past whilst forewarning of something that is predicted to take place in the future (Campbell, 1988; Kirby, 2007).

The second section of this chapter specifically addresses the Ngāi Tahu creation narratives and what has been learnt through the retelling and understanding of these significant iwi (tribal) stories. African American Professor Jimmy Kirby Junior

captured the essence of why tribes use stories and storytelling to convey meaningful tribal detail in his paper at the National Council for Black Studies Conference in San Diego 2007. Kirby stated,

To truly understand and fundamentally know a 'people', it is crucial initially to study and understand the cosmogony of the people, that is, how those people view the creation of the world and how they view their relationship with and within it. Their theory of the origin of all life – where they believe they came from and how they came to be – directly influences their worldview. This central theme, telling the beginnings of the world, teaches the elemental events and ideas that made humanity what it is, thus everything is connected with its existence (p.3).

Creation mythology provides a rich opportunity to explore the origins of tribal values and customary practices. In section three of this chapter, the next step in human development is addressed with a brief overview of the arrival of Ngāi Tahu into Te Waipounamu (the South Island). Key historical events are discussed, such as the arrival of the whalers and sealers, trading of goods, tragic battles between iwi, the signing of the Treaty of Waitangi, land transactions and the loss of cultural practices and rituals throughout the 19th and 20th centuries.

Section four concludes this chapter with a summary of key points learnt through the historical overview retrieved from a variety of learning sources. This knowledge serves to guide the research focus and to establish the most appropriate theoretical framework to house this doctoral thesis.

2.1 Section One: The Power of Birth

Women are the first environment. In pregnancy our bodies sustain life. At the breast of women, the generations are nourished. In this way, we as women are Earth (Cook, 2003, n.p).

Katsi Cook, a Mohawk Native American grandmother and midwife, says that her elders taught her that it was a privilege to be a woman and hold the gateway to life. From the bodies of women flow the generational connections to each other and to the natural world. This is why they exclaim that women are earth. The Mohawk term for midwife is *iewirokwas*, which translates as “the one who pulls the baby from the earth” (Cook, 2003, n.p).

Birthing is viewed as a “heroic deed” a sense of giving over a life in order for another to be created (Campbell, 1998, p. 125). Mother Earth has often been associated with land, agriculture and the birthing and nourishment of plants. She is a very important goddess in planting cultures that depended on their crops for their own survival and as trading commodities. In ancient Mesopotamia and in the Egyptian Nile Valley, Mother Earth was a dominant mythical form, perceived as a goddess having the most esteemed power of creation. Women carry life and therefore, they carry the same powers as those bestowed upon Mother Earth (Campbell, 1988). Both earth and women are symbols of compassion, producers of form and reflections of the primal mother. Campbell (1988) states that around 1750BC the power of the Mother Goddess was forced aside by the dominating male gods portrayed in mythology. He discussed it as an invasion of the world by the Semitic people when the male god Marduk in Babylon annihilated Tiamat, the almighty Mother Goddess. From this moment on, says Campbell, the male-orientated myths took over after which the creator is then viewed as male (1988).

Author Howard Parsons (1975) states that in the agrarian cultures the male figure was a partner to the Earth Mother, yet he was the dominant element of the two, and this appeared to be the consensus even as the cultures traversed to the West. Webb (2001) highlights the reproduction influence of agrarian culture within the Bible, which describes women as providing the “soil” for the male to deposit his “seed”; the harvesting of the crop is the birth; and the baby is the fruit of the woman’s garden or

womb (PS 78:51; g105:36, New American Standard version). In John Mason's (1998) book, *An Unnatural Order: The Roots of Our Destruction of Nature*, he describes the agrarian cultural worldview as being based on a ranking of every living thing. Cultural geographer, Clarence Glacken, concurred in 1967 with his theory on the hierarchy of living beings, which stated that Western agrarian cultures claimed that animals existed for men, and men as stewards to God. This, wrote Glacken (1967), gave men a god-like authority over the earth and ranked women closer to the animals, with their primary role being breeders and child minders. The once "heroic deeds" of women in childbirth was demoted as they became subservient to men. This thinking was perpetuated in hierarchical theories devised by men that kept women in an oppressed state of being for centuries (Glacken, 1967).

Ironically, the reclamation of the Earth Mother status for women by women was to remember their childbearing power and remove themselves from subjugation. It is in the birthing ceremonies that many Indigenous women realise their strength and their admirable role within their family and community. Metis-Cree writer Kim Anderson contends that the liberation of Indigenous women assists in the recognition of self. The sharing of ancient stories and the role of women as creators aid women to remember and feel empowered by their primal function in their community (Bruyere, 2012; Gonzales, 2015).

The hospitalisation of childbirth has led to a natural process becoming layered with complications that go beyond the inability for Indigenous women to birth in their home villages and more severely to the denial of cultural knowledge and identity (Bruyere, 2012). Many authors have described this transition as the medicalisation of birth and the sanitation of a culture (Benoit, 2001; Bruyere, 2012; Gonzales, 2012; O'Neil and Kaufert, 1990). The removal of cultural values by another dominating body to improve (in their minds) the status of the Indigenous collective can result in generations of cultural damage. Birthing naturally has been perceived as being non-compliant with biomedical practices, and unsafe from both the pregnant woman's and the midwives' perspective (Kitzenger, 2011). The power of women to birth at home or with minimal medical intervention has been eroded by the medicalisation of birth. By normalising hospital births, the decision to birth away from sites of specialist care has been rendered as "risky" (Kitzenger, 2011).

Māori women were birthing in a hospital setting by the late 1950s and early 1960s, however, this transition away from the home and whānau led to some interesting statistics for Māori in maternity (Donley, 1986; Gulliland & Pairman, 2010; Papps & Olsen, 1997; Stojanovic, 2008). In 2017, New Zealand women birthed approximately 60,000 babies; of these babies almost 15,000 were Māori. Of these Māori babies, many were born in a primary birthing facility or at home. Currently, the average age of Māori women giving birth is 26 years. Māori women aged between 20-24 years have the highest fertility rate of 156 per 1000 births, with the second highest fertility rate of 149 per 1000 births also Māori women in the 25-29 age bracket.

As a culture, we have a productive birthing future, which will enhance Māori population figures. However, there are some serious Māori maternity health issues to be rectified. For instance, 48 percent of Māori women giving birth are more likely to live in a quintile 5 area; these are the most 'deprived neighbourhoods'. Māori women giving birth may also fall into the second highest group for obesity, and they have a higher proportion of smokers recorded at the time they register with a Lead Maternity Carer. Smoking is the likely contender for the low birth weight of newborns; of which Māori have more underweight babies than non-Māori at 6.4 per cent (MOH, 2017). Associate Professor Marewa Glover co-authored an international narrative review of literature on smoking among Indigenous pregnant women in the United States, Australia, Canada and New Zealand in 2016. The findings highlighted the need for interventions to be at the family and community level. To draw upon the relationship they have with the elders and community health workers, as role models of non-tobacco use and pillars of cultural strengths. Glover (2017) alongside the international team of researchers believe government funded Indigenous-led and culturally based programmes will be conducive to reducing the smoking rates of pregnant Māori mothers (Curtis, 2017; Gillian et al., 2017, Roberts et al., 2017). Improving the hauora (health) of Māori mothers through strengthening cultural connection and role modeling is not always perceived as a convincing solution. Page (2016) argued that because medicalised interventions are the norm all other treatment suggestions are perceived as less important than the Western clinical measures. Page's (2016) view of birth refers to what she sees as an over-prescription of birthing interventions, such as caesarian sections, the use of birth instruments, higher rates of anaesthetics and ongoing fetal monitoring. The rates of birthing intervention in New Zealand, such as inductions and

episiotomies have increased between 2005-2017 from 19 to 24 per cent. One out of every two women giving birth in New Zealand will experience at least one medical intervention during their labour or birth (MOH, 2017). One of the birthing interventions more frequently used nationally and internationally, is the caesarian section (CS), whilst vaginal deliveries have reduced (MOH, 2017). The CS rate for New Zealand is 25 per cent of all births, this equates to one quarter of New Zealand women birthing per year, a rate that the World Health Organisation (WHO) sees as too high. The WHO recommends a global CS rate not higher than 10 per cent of all births and that CS should only be conducted when deemed medically necessary (2010). The Ministry of Health's *Report on Maternity* (2017) stated that Māori women were less likely to get a caesarian section in either an elective or in an emergency situation compared to non-Māori; Māori were also less likely to have epidurals and only 6.7 percent of Māori women birthing require an episiotomy.

Grigg et al., (2017) compared birth outcomes associated with primary midwifery-led birthing units and tertiary obstetric birthing units in the Canterbury area in 2010 and 2011. Of the 693 participants, 407 women intended to birth in a primary birthing unit (PBU) and 285 intended to give birth in a tertiary maternity hospital (TMU). The main consideration for women choosing TMUs was feeling safe and close to specialist care if needed, on the contrary, those who intended to birth at the PBU chose this site to avoid medical intervention with the aim to have a natural birth. Another reason given for women wanting to birth at a PBU were so they could be closer to their home and family. These women felt the atmosphere of PBUs were more relaxed and more inviting than those provided in the public maternity wards. The results of this study indicated that midwifery-led freestanding PBUs are safe places to birth for women who are well. The study also surmised that women in PBUs have higher rates of vaginal births and less medical intervention than those who birthed at the TMU with no difference between the neonatal outcomes in either setting (Grigg et al., 2017). A greater number of Christchurch wāhine Māori (7.4 percent) in this study birthed in a PBU in comparison to the 2.1 percent of wāhine Māori who birthed in a Christchurch TMU (Grigg et al., 2017).

Overall, Māori women are less likely to need medical intervention in their births, are younger when they birth and are birthing at a higher rate than non-Māori (MOH, 2017; Statistics NZ, 2017). The power of birth contains the energy and the knowledge

pathways for Māori to reclaim their customary birthing practices to enhance their birthing experience. The creation of the universe commenced the origin of customary birthing practices, and creation mythology stores ancient narratives handed down through the generations to ensure this poignant knowledge would never be lost. To better comprehend Māori customary birthing practices is to understand the significance of mythology as a knowledge transporter.

Mythology

Mythology viewed via a cultural lens has been described as a repository of important cultural knowledge and/or social etiquette, Professor Jimmy Kirby (2007) states that creation stories are often placed under the banner of “mythology” with little explanation; yet Kirby stresses that African people have clear distinctions between the types and expression of myths. He said some myths are used to entertain with the intent to reinforce cultural morals, and other myths express sacred narratives conveyed through symbolism. The latter type of myth offers a deeper spiritual method of teaching creation narratives. Kirby (2007) reminds the reader that different cultures perceive and value creation stories as real and purposeful knowledge expressions. When articulated or categorised by people not of that culture, the detail can be lost. Karen Armstrong (2005) looks further into the layers of myths when she describes the content of myths as nearly always about death or the fear of extinction. She believed they often contain a sacrificial element that is strongly aligned with ritual. Powerful myths are those that talk about extremities and compel us to step out of our comfort zones. Myths show us how to behave, Armstrong (2005) claims, they prepare us for life after death by aligning our physical to our spiritual being.

Greek and Hebrew descriptions of mythology establish the connections between deities and people. Therefore, through mythical recall, people are able to trace their ancestral links back to a deity. This gives them a strong sense of pride and place through their connection to these gods (Burkert, 1982). Armstrong (2005) concurs that mythology speaks about the world of the gods that is invisible and exists to assist the world we are in. The term Armstrong uses is *perennial philosophy*, which relates to everything in the world corresponding to something in the celestial realm that is more elaborate, stronger

and longer term than anything in the world we currently live in. In addition to Armstrong's philosophy, the late Ranginui Walker (1978) spoke of the overlapping and corresponding knowledge between the physical and spiritual realms in the Māori world. Walker referred to "myth-messages" as description myths that remain as poignant today as they were in previous generations. Walker (1978) believed that myths provide instructions on how to manage difficult and challenging dilemmas and he supported anthropologist Ralph Piddington's reference to myths as symbolic expressions of social values. Piddington related present day practice and beliefs to events in the distant past (Walker, 1978, p. 406).

Reverend Māori Marsden (1992) is another Māori scholar and philosopher graduate of the Ngā Puhi Whare Wānanga and author of the book, *The Woven Universe*. This book aptly describes the weaving together of what was mentioned above with his understanding of myths to form a model of learning known as *Te kete o te Wānanga* (the three baskets of knowledge). Marsden (1992) explores pre-Christian theology and divinity through both his Christian lens and Ngā Puhi worldview. In his writings about kaitiakitanga (guardianship), Marsden (1992) states that myths form the central system and from there Māori shape their worldview. He refers to myths as a "deliberate construct" to highlight the relationship between the "creators, the universe and man" (p. 2). The three baskets of knowledge, according to Marsden (1992) encompass a worldview of te iwi Māori, as they contain three masses of energy that work in unison to create life:

- *Tua-Uri* encompasses the world beyond the natural world and the world we can sense, says Marsden. This world enters a darkness that forms the platform of creation. A place where growth and evolution take place to eventuate in the birth of the natural world. Whilst this is occurring, there is a constant rotation of energy in ultimate balance with each other. Marsden describes these units of energy in the cosmic process as: Mauri, Hihiri, Mauri-Ora and Hau-ora. Mauri creates relationships and brings about connections. Hihiri is a pure energy that radiates from matter and living things. Mauri-ora gives life and what is needed beyond hihiri (pure energy) by allowing things to live. Hau-ora is the breath of life or a spirit that enters at birth to provide life.
- *Te Ao-nui* is what goes before us. This is the natural world, and this reflects all the genealogies of everything. This kete reminds us that everything has a

whakapapa. Marsden (1992) says that this kete embraces the recurring life cycles and events that have taken place; and what learning was occurred through this cyclic occurrence. This became knowledge that was transferred through the generations.

- *Te Ao Tua-atea* is the world beyond space and time. Atea is a word that describes space and the wā refers to time. When combined, these two words produce the word wātea that equates to space-time. It is within this very product of space-time that Ranginui and Papatūānuku were born. Marsden (1992) states that Tua-atea is infinite and eternal; he says it is the spirit world and for Māori their “ultimate reality” (p.10).

Marsden describes the cyclic transition from dark to light as being synonymous with birth when the baby transitions from the whare tāngata (uterus/womb) to the world of light (physically being born). Ngāi Tahu also share this philosophy as evident in their creation mythology (Beatties, 1990). Marsden (1992) also states that, in order to understand and remember the relationship between the “Creator, the Universe and man”, myths and legends were constructed to hold a great amount of information in a compact format, which upon articulation would guide the audience to perceive their world a particular way and know their place within it. Therefore, myths enable recall of knowledge, but they are also protective in their function. Only those who know about sacred lore would be able to interpret the hidden meanings within the myths.

Armstrong (2005) describes the creators in mythology like a hook that would capture their listeners and inspire them to elevate their thinking to another plane to “experience divinity themselves” (p. 5). This appears to be a survival mechanism that has helped people through difficult situations. It has reminded them of their “innate sense” to cope when times are difficult, or to explain something that does not make sense in their world (Armstrong, 2005, p. 7).

Defining a myth as different to a fable, folk story, fairy story or parable can become strenuous and depending on the interpretation you feel more aligned with. The Greek term mythos has a range of meanings; including a “saying” or a “story” but it also implies “fiction”, and it is this word that can throw a shadow of doubt over whether mythical stories should be viewed as true and accurate. Many could then associate myth with fantasy stories that can be synonymous with an erroneous belief. Often, you will

hear people using the term “myth” to describe something that holds no truth or in reference to something we should pay no attention to as it is simply wrong (Brzezinski, 2015; Encyclopedia Britannica, 2016).

Joseph Campbell (1998) discusses how important it is to understand mythological stories from all around the world, including Māori stories. He likens mythology to songs when he says, “It is the song of the imagination, inspired by the energies of the body” (Campbell, 1988, p. 220). Campbell contends that myths remind or refocus the people by harmonising the mind with the body or vice versa. He acknowledges that our minds can easily be distracted, and myths and rites return the mind back to working in accord with the body. The body does not only mean the physical structure of a human but, in a wider context, it is viewed metaphorically as an organ that is part of a larger organism. Similarly, our societies are “organ(s) of a larger organism and the larger organism is the environment we live in – our landscape, our world” (Campbell, 1998, p. 72).

Bronislaw Malinowski was an influential anthropologist in the 20th century. His style of research methodology at the time, in 1915, was uncommon. Malinowski conducted lengthy research on the Trobriand Islanders situated on the North East Coast of New Guinea during World War I. He wrote about the Trobriand Islanders’ mythical narratives with such accurate insight that his writings remain incredibly popular and relevant today, more than 70 years post his death. Malinowski saw myths as part of the pragmatic dimension of culture (Strenski, 1992, p.xi). Myths were “part of activities which do certain tasks for particular human communities”. Myths to the Trobriand Islanders were part of a bigger reality that legitimised their social organisation and the hierarchy of power (1948). Therefore, Malinowski argued that myths provided a charter for the Islanders to live by. He commented that a full understanding of the narrative of a myth is only possible if the context in which the myth has originated is understood, including the people’s: religion, society, philosophies and perspectives. He also contended that myths are linked to humans’ “basic biological needs”, and are pivotal to the protection of morality, defending rituals, enhancing beliefs and providing practical guidance for people to follow (Strenski, 1992).

Malinowski (1948) stressed that the Trobriand Islanders’ myths were founded on their social organisation, which were reinforced not only hearing about the myths but by

living them out or, in other words, the myths live within the social fabric of the tribe. Trobriand Islanders justify their social norms through living their mythic traditions. Malinowski said that myths provided a “social code of behavior” that appeared to validate the very existence of the Trobriand Islanders; myths gave their lives purpose. He also discussed the morality that myths provided and how much they aided in the transition phase from child to adult (Malinowski, 1948).

Campbell shares this view also when he says that myths support a social order, and they hold an educational function that assists humans to live in any circumstance (1988). Myths form a platform from which cultures can perceive their universe. How a culture perceives the world comes down to how they perceive reality from their worldview (Campbell, 1988; Samples, 1982). The retelling and understanding of Ngāi Tahu “myths” thus provide insight into the organisation and governance of traditional Māori society. Such an understanding draws heavily on interpreting the symbols that are prominent within Ngāi Tahu creation storytelling.

Symbolism in Mythology

Motifs and poignant references to symbols within mythical stories connect the reader to another character or set of stories that have happened either prior or alongside a particular story (Campbell, 1998; Kirby, 2007, Thornton, 1999). Having an awareness of what symbols portray, such as an animal, instrument or plant, offer an understanding of the layering within a story. Thornton (1999) describes this as the submissive code that, once understood, provides the listener or reader with all the clues to unlock the true meaning of the story. The use of symbols as a communication tool between groups, and from one generation to another; express their cultural foundation and understanding of life (Gonzales, 2012). Symbolic communication is recognised as an essential Indigenous mind tool that carries encoded knowledge (Cajete, 2016; Gonzales, 2012).

Māori symbols, it is thought, were developed to help Māori use all of their senses and knowledge repositories within themselves to reconnect with the world in front of them, the worlds before, and the spiritual domains. These symbols help to form a cultural worldview that shapes their “perceived reality” and includes the things that are “actual,

probable, possible or impossible” (Marsden and Henare, 1992, p. 3). How cultures perceive themselves in their world are the very axis of their existence, influencing every aspect of their culture. The dichotic nature of symbols allows access to layers of cultural knowledge but, equally, they could obscure true meanings. In this way, symbols keep knowledge hidden from enemies and accessible only to those who are perceived to be the guardians of tribal knowledge (Marsden and Henare, 1992, p. 3).

Equations and formulas have been embedded into symbols illustrated in Māori and Mexican Indian art, for example: bark, pottery, buffalo hide calendars, rock, stones, tukutuku (a lattice-style artwork) and whakairo (carvings). They convey a depth of information concerning the people and the natural world they dwelled in. Patrasia Gonzales (1985) addresses these coded equations as thought formulas, which articulate a natural philosophy. Symbolic communication is tantamount to Indigenous practices expressed within cultural ceremonies (Gonzales, 2012). More research, time and expertise would be needed beyond this thesis and literature review to gain the ability firstly, to recognise symbolism within art forms and secondly, to decode and translate the information they hold. For this literature review, the importance lies in acknowledging that symbolism exists and recognise they, like the myths themselves, are knowledge carriers.

Donald Fixico (2000), scholar and writer of American Indian history, believes mythological symbolism and associated narratives can assist people to take meanings and values from these original stories to guide contemporary life. Gonzales (1985) agrees and adds that the return to original or traditional knowledge reminds our Indigenous communities of their relationship with the natural world. She believes if we can obtain and maintain this relationship, we will fully understand our relationships to creation and to each other.

Māori Creation Mythology

Hakahaka Te Raki i ruka nei i ruka nei, ko te pō koua tupu
Though the heavens hang low there is growth in the dark
Even in darkness there is life, from darkness life emerged
(Tau, 2003 p. 79; Shortland, 1882, p. 23).

Two defiant Ngāi Tahu leaders in the middle of a deadly warfare were said to have uttered the above whakatauākī. This was perhaps said to lift their spirits and in the hope that, even in their darkest hour, something positive could take place which might rescue them from their situation. This whakatauākī also features at the beginning of the Ngāi Tahu creation karakia (incantation) moving from darkness to light, which is also about transitioning from the spiritual world to the physical. Māori cosmology is the Māori worldview and highlights the relationship Māori have with nature and the personification of natural elements (Tau, 2003).

In a revised edition of A.W Reed's 1963 *Treasury of Māori Folklore*, titled *Reed Book of Mythology* (2004), it was noted that in the first edition Reed merged versions of tribal mythologies to create one overall narrative about the origin of the Universe and the interesting characters that came forth from this phenomenon. Originally, Reed felt that it was important to expose these stories to the world and that creating stories that were a hybrid of many iwi would perhaps be more entertaining and inclusive. Reed, however, was criticised for composing his own take on stories, as the constructed stories could wrongly be perceived as true and accurate. Reed gathered creation stories from the archives of historians like Elsdon Best (1924), J.F.H Wohlers, Sir George Grey (1953), James Cowan and Maui Pomare (1930) and John White (1887), and by accessing volumes of the Journal of Polynesian Society and Transactions of the Royal Society of New Zealand (1880).

Since Reed's 1963 edition, a cultural renaissance across Aotearoa has exposed more tribal stories, leading to pressure from descendants to have these stories told correctly and as their own entity. Ross Calman (2004) took up the challenge to authenticate the stories; his approach was to correct the blatant mistakes and misunderstandings in the stories with integrity, and a sense of 'tika' (to improve by correcting the mistakes made by non-Māori historians). The 2004 version of creation mythology provides a wiser and more respectful array of tribal creation stories that hold their own mana and are not jumbled into one story. This differentiation of tribal stories acknowledges that there are deviations on the same story, and this positions them with a particular region and/or iwi. Calman's (2004) approach removes the colonial lens that grouped stories into one

easy-to-digest story for non-Māori to a more personal perspective identifying the iwi and hapū that the mythical stories came from.

It is easy to get caught in spending numerous hours trying to find the original creation story or the, perhaps misguided, “true” creation story, as I was attempting. However, my cultural advisor and the writings of AW Reed (2004) and Agathe Thornton (2004) reiterated that when reading the many narratives on mythology one should not look for truth or pick one narrative over another but look for meaning and messages within the stories. It is of more benefit to find the common themes of the creation stories and address what these themes are about than to seek the “real” story (Reed, 2004; Tau, 2016; Thornton, 2004). Joseph Campbell also resolved my division of thought when he posed the same question in his book, *Power of the Myth* (1988). He asked this rhetorical question, “are some myths more *or* less true than others?” Campbell then replied,

...true in different senses. Every mythology has to do with the wisdom of life as related to a specific culture at a specific time (p. 55).

The Māori creation story is perhaps the most significant mythical narrative that holds multiple iwi variations. However, many would also agree that there are key elements that do not differ in their interpretation. The period defined as Te Pō is a time of potential, creation, conception and development (Beattie, 1990; Marsden, 1992, 2003). Reed (2008) stated that Pō was the realm of primitive life, that earth was taking form in the engulfing darkness of Te Kore with the sky pressing above the budding earth. The first six of the twelve Te Pō stages of darkness described by Reed took place prior to the conception of Papatūānuku. The next group of Pō referred to the labouring stages that led to the birth of Papatūānuku. The individual names of the many Pō were derived from the many stages of labour and birth:

Te Pō te Kitea
Te Pō Namunamu ki taiao
Te Pō Tahuri atu
Te Pō Tahuri mai ki taiao.

The unseen, the changing and untouchable (a possible reference to the fetus in utero), then the turning of the baby to the passage of light or the birth canal (Te Pō Namunamu ki taiao) as the baby and mother begin their labour journey. Then the movements a baby

makes to get its head and shoulders into the correct position to descend the birth canal and be born. Poignant connection between the birth of Papatūānuku through ‘te ara of namunamu ki taiao’ (the passage from which we enter this world) and viewing our birth journey into Te Ao Marama (Reed, 2008).

The following karakia (incantation), *Na te Ao*, written by Matiaha Tiramōrehu depicts another account of the creation mythology and the realms of Te Kore (the intangible void):

Ko te Ao Tūroa
Tana ko Te Ao Marama
Na Te Kore
Tana ko Te Kore Whiwhia
Tana ko Te Kore Te Kerekere
Tana ko Te Kore Te Taumaua
Tana ko Te Kore Te Matua
Tana ko Mākū
Ka moe ia i a Mahoranuiātea
Ko te Raki
Ka moe ia i a Pokoharunuitepo
Ko Aoraki me Rakamaomao tana a Tāwhiri a Matea
Ko Tū Te Rakiwhanoa
Uira ki Te Mahunui a Maui
Ko Te Ao Tākata
(Tau, 2003).

This whakapapa chant above highlights the arrival of the natural world, from the many stages of darkness, from the first glimmer of light to the longstanding light surrounded by the intangible kore full of potential. Te Māku is the mist and moisture coupled with Mahoranuiātea, a cloud that was drawn from dawn. They begat Rakinui (the Great Sky or Sky Father) who partnered with Pokoharua-Te-Pō and they had Aoraki (the supreme mountain of Ngāi Tahu) and the winds Rakamaomao and Tāwhiri-a-Mātea. Tū Te Rakiwhanoa, another atua in the karakia, was credited for using his adze to carve up the southland fiords and Te Maharanui a Maui is the name of Maui’s waka (canoe) and later identified as the piece of land between the Clarence and Waitaha rivers. The last line of this karakia states “Ko Te Ao Tākata”, which announces the arrival of humanity (Tau, 2003). Each karakia, like the one above by Tiramōrehu, give poetic expression to another thread of the creation story by introducing another atua or identifying a place. Often the karakia we access today are shorter versions of much larger karakia that envelop the many tiers of creation in great detail. Accessing these old karakia is

difficult, and perhaps for some iwi virtually impossible. However, the verses of karakia we do have and the pūrākau on the same themes allow us insight to the voluminous depth the whakapapa of the Universe has, and how precious these karakia are to Ngāi Tahu (Marsden, 1992; Morgan, 2020; Tirakatene, 2016).

Atua associated with birth

Female deities were beckoned through karakia (incantations); the word “hine” is a term of address and refers to a girl or younger woman. Hine is also a term of endearment and respect stemming directly from the feminine atua (deity), Hine-ahu-one, the first woman created by Tāne, and her daughter, Hine-tītama, who became the goddess of death, Hine-nui-te-pō. The atua associated with creation and birth are Hine Marama, Hine Te Iwa Iwa, and Hine Akeake; they would be specifically appealed to in karakia to assist with a successful conception and birth (Gray, 2010; Tikao, 1990). Hine Te Iwa Iwa was also known as Hine-Uri and Hine Keha in other parts of Aotearoa. She was not only seen as the kaitiaki of childbirth, but she was also a powerful goddess in mahi raranga (weaving) (Flutey-Henare & Parata, 2018). Other goddesses associated with childbirth, noted in Best (1975), were Hine Korito, Hine Makehu, Hine Kotea and Hine Korako, who is often personified as the moon’s halo or lunar bow (Mead, 2003a). Another goddess associated with childbirth, was Pani or Hine-Tinaku, she was said to be the mother of the kūmara plant (Riley, 1994). However, the universal and first mother of humanity was Papatūānuku (Earth Mother) through her creation of life cycles and her role-modeling of primal motherly instincts, such as love, protection and nourishment (Mead, 2003a; Palmer, 2002).

Through these pūrākau (stories) and the exploration of atua wāhine we can delve a little deeper into cultural concepts to further comprehend the importance of childbirth tikanga and other tikanga associated with wāhine. The concept of tapu (sacredness) is irrevocably linked with the spiritual role of women and childbirth. Tau (2003) explains, for example, in his book, *Ngā Pikitūroa o Ngāi Tahu*, that Te Pō is a female element. Tau claims that a woman’s womb is a containment of “unreleased life”, and he likened this to the tapu that dwells and exits within Te Pō (p. 73). Tau distinguished that the

womb is not the origin of tapu, but the space in which tapu exists; and that tapu is not the womb of a particular wāhine but of all wāhine who are represented by the deity Hine-nui-Te-Pō (the goddess of the night or realm of death).

Yet writer and historian Judith Binney (1986) argues the contrary, that tapu is from within the womb and she recalls the stories of Māori women she interviewed for her book, *Ngā Morehu: The Survivors, The Life Histories of Eight Māori Women*. Binney claims that her interviewees shared that the specialised role of the whakanoa process or lifting of tapu was assigned to high-ranking women or those who were beyond menopause (known as ruahine or ruawāhine). The whakanoa ritual involved drawing the tapu into their womb and then sending it back out to the atua and other spiritual forces. Binney surmised from the interviewee's that the womb was the origin of tapu. Hence, why the whakanoa (lifting of tapu) can only be assigned to mature wāhine who are beyond their childbearing years. It was believed that if a mātauku (curse) or infringement of tapu occurred, that the girls and women in their childbearing years were spiritually unprotected; resulting in their whare tāngata (womb) being disturbed. Wāhine are the generators of the future population and therefore need to be protected in ritualist processes (Binney, 1986, p. 26).

Taua (elderly woman) and/or puhi (virgins) are given the role of lifting tapu from objects and returning the tapu back to its normal state or back to te Pō (the night). The whakanoa ritual of a new whare is often done with the taua and puhi walking over the threshold to lift the tapu, making the whare ready for others to enter. The post-birth ceremonies are also to cleanse the space and mother from the tapu (Tau, 2003, p. 73). Tau did concur that some Ngāi Tahu traditions provide evidence of the mana of the wāhine. For instance, in the Moki tradition, when Moki the rangatira led Ngāi Tahu's movement into the domain of Waitahi; Moki made sexual derogatory comments to two Ngāi Tahu women and this was believed to be his downfall, as a makatū (curse) was placed upon him for his disrespect. He died and this action was said to have confirmed the taputanga of the wāhine, especially when disrespect is shown towards the sex that births the generations.

Similarities can be seen with Maui's endeavor to secure immortality for humanity by reversing the life cycle and re-entering the birth canal of the goddess of death, Hine-nui-Te-Pō, through her vagina, which was recorded in most mythological stories as

unsuccessful, resulting in the death of Maui (Pomare & Cowan, 1977). Yet Ngahuia Murphy's research pertaining to perceptions of menstruation in Māori shed another light on this story, which was shared with her by Tuhoe educationalist, Rose Pere. Pere's version of Maui's quest for immortality sees Maui achieving this wero (challenge) but in a form that was empowering for wāhine. Hine-nui-te-Pō granted Maui eternal life by changing Maui's form into the blood that flows like a river from wāhine every month during menstruation. Pere termed menstruation as Te Awa Tapu or Te Awa Atua, meaning the godly or sacred river in reference to the return of the deity Maui every month when he is rebirthed within the menstrual flow (Murphy, 2014).

In this section, the power of birth told through karakia, mythology and symbolism of creation; and the spiritual lores, such as tapu (sacredness) and noa (ordinary) were deemed the only way to begin this mahi (work). Thereby, this thesis highlights the potency of birth and recognises the mana of wāhine Ngāi Tahu in Te Ao Tawhito.

2.2 Section Two: Ngāi Tahu Creation Narratives

Matiaha Tiramōrehu, a learned leader, was taught through the *whare pūrākau* (the art of war) at Kaiapoi and attended many *whare wānanga* at Taumutu and Ōtākou. He shared his teachings about Ngāi Tahu mythology in manuscripts sourced through the Hocken Library (Tiramōrehu, 1881). Tiramōrehu said that Rakinui (Ranginui – Sky Father) was begat by Te Mākū and Mahora-nui-ātea. Rakinui lived with Pokoharu a *te Pō* and they had many children before Rakinui met Papatūānuku, who at the time of their meeting was partnered with Takaroa. It is said that whilst Takaroa was away burying the *whenua* of their latest offspring, Rakinui and Papatūānuku came together and conceived a number of children. Upon the return of Takaroa, he challenged Rakinui at the beach to a feud. The battle ended with Takaroa piercing the upper thigh of Rakinui. In victory, Takaroa walked away commanding Rakinui to remain with Papatūānuku as their relationship was no more (Tiramōrehu, 1987).

The children that were born of Papatūānuku and Rakinui following the feud with Takaroa were said to be sickly or disabled. Rakinui knew this was a result of his coupling with Papatūānuku whilst she was with Takaroa. Rakinui directed Tāne and his younger brothers to remove him to put an end to his relationship with Papatūānuku and as his penance for causing his *tamariki* (children) to be born with disabilities. Rakinui told his son, Tāne, that through granting this request light would be shed across the world, aiding the growth and development of his *tamariki* locked within the parental embrace. Tāne placed his body against Papatūānuku and, with the help of his brothers, managed to separate Rakinui from Papatūānuku. As Tāne lifted Rakinui up into the sky, separating him from Papatūānuku, Rakinui created another heavenly layer. Rakinui then instructed Takaroa to stabilise the separation by placing *pou* between Rakinui and Papatūānuku (Tiramōrehu, 1987).

Matiaha Tiramōrehu died in 1881. His birth date is suggested to be 1800 but it was thought he was well into his 80s when he died. Teone Tikao was another Ngāi Tahu knowledge gatherer who was born when Tiramōrehu was in his 50s. Since Tiramōrehu's death, the number of *whare mātauranga* (knowledge houses) had declined due to the impact of colonisation (Beatties, 1990). Tikao's father, Tamati, sent his son in 1858 to study under two *tohunga*, Koroko and Tuauau, they were known for their

skill in ancient knowledge. Unfortunately, Koroko died a year into Tikao's time with him and Tuauau died less than a year later, ending Tikao's time with these knowledgeable men. Tikao then went on to spend time with other learned men in the area who shared what they knew about Ngāi Tahu traditions; one of these tribal historians was Paora Taki (Beattie, 1990). Tikao was aware of a variety of education houses that provided in-depth tribal knowledge these were known as: the Whare Mauri – often referred as the house of general knowledge, the Whare Kura (religion and metaphysical knowledge), the Whare Pūrākau (to teach the art of war), Whare Maire or Mauri (general knowledge), Whare Wānanga (to rehearse ancient matters) and Whare Mata (to practice the cutting of greenstone/pounamu) (Beattie, 1990).

Tikao (1990) said that when Rakinui instructed Tāne to push Rakinui and Papatūānuku apart, a pole or pou was used to assist Tāne to separate his parents, which was named Pou-tū-te-rangi. There were ten joints on this impressive pou, and these joints represented the heavens that were created when Rakinui was hoisted into the air and held in place by Pou-tū-te-rangi. Although Tiramōrehu was a tuakana to Tikao, both were affiliated to Tūāhuariri and they carried strong connections through whakapapa lines. Still, the variations in their creation knowledge highlight how many versions and perspectives within the one iwi and hapū can exist, none more or less truthful than the other (Beattie, 1990). Tikao's creation version does not disclose that Rakinui had many wives and that Papatūānuku was his second wife; nor did he mention that Takaroa was Papatūānuku's first husband and they had had many children before she coupled with Rakinui, as Tiramōrehu described in his creation narration. Tau (2017) felt that Tiramōrehu, Tikao and other Ngāi Tahu informants most likely all learnt the *Te Pō* and *Raro Timu* creation narratives, but the recordings of their knowledge are incomplete, and can appear to be different creation stories. Tau feels they are the same story, but the variations are a result of some informants including certain details and others not.

Historians such as Best (1979) and Beattie (1990) scribed their interviews with tribal informants. Best wrote his thoughts into the body of the text and Beattie kept his own views to the footnotes. In doing so Beattie kept the integrity of the tribal accounts unspoilt by his non-Māori opinions or thoughts entering the text. In the foreword of *Tikao Talks*, Beattie acknowledges that Tikao became frustrated with Beattie's lack of Māori language and his inability to write it correctly. Therefore, Tikao started writing his recollections himself to ensure it was punctuated and spelt correctly. Beattie (1990)

felt no malice in Tikao's action but a necessary solution to speed the research process up and make it a little easier for both himself and Beattie.

Tikao told Beattie about a creation karakia that was taught to him when he was 10 years old but that he could not translate in its entirety. It is a karakia about the whakapapa of all things that came from what could be perceived as four primary roots. The first root being Io; acknowledged by Teone as the Supreme God, and the most crucial and important root of the four roots. The second root commences with Te Pō ko Uatipu or Te Pō Koua Tipu (Koua is Ngāi Tahu for "kua" and can also be read as Te Pō Kua Tipu). The series of Pō (periods of darkness) commences and is followed by Kore (periods of nothingness). The third root is Raro-timu; this root originates in the ocean.

The first two lines of the karakia (incantation) begin with Raro timu, Raro take, and Teone says this indicates that this root came from beneath the ocean. *Timu* and *take* are words to describe a root. Teone says in the beginning there was nothing but the sea, which was enveloped in a realm of darkness. It was from this ocean foundation that lifeforms emerged. The fourth root is Tiki, of which the fish, birds and humans descend. The fish came first and over time the human body evolved.

Raro-timu – the root beneath the sea;
 Raro-take – the deep root – the original root;
 Raro-pou-iho – to dig a hole and place a post in it;
 Raro-pou-ake – turn the pole around or position up;
 Ko Takū – strengthen the pole make it secure;
 Ko Takeo – takū – keep securing the pole, ensure it is done;
 Io-io-whenua – the power invested in Rangi and other elemental gods, other interpretations is that this is the name given to the oldest son of Rangi and Papa, others say this is the name of a star and represents peace;
 Tipu-kerekere – this, says Tikao, is a term for thick or dark clouds, it embodies power and it is perhaps the name of an entity or god. This term seems to conjure up a sense of an expansion of an idea or energy;
 Tipu-anana – the suspense mounts;
 Kai-a-Hawaiki – when Io lifted Papatūānuku from the sea Hawaiki was part of the land raised. The first place that Māori lived before beginning their migrational journey. A founding place for Māori or a significant location;
 Ko Matiti – this is the name of a sacred house;
 Matiti-tua – beyond the sacred house;
 Matiti-aku – at the sacred house;
 Matiti-aro – in front of the sacred house, this could refer to the whare tāngata;
 Ko-teke-ehu – the vagina was seen, and the opening was revealed;
 Te Whare-patahi – as the baby descends the birth canal, the cervix has opened to allow the baby to come through the vaginal opening and into the world;
 E Hui-te-rangiora – this is a place near Pikopiko – whiti situated according to Tikao near the end of the world where Maui was said to be born;
 E Rongo ki waho matatahi mai te ara o tu manuhiri tua-rangi kei tawhiti te kai; kai te waro te kai te kainga tu ko ko I tu ha – Rongo is perhaps in reference to Rongo-hīrea or Rongomatane, another son of Rangi and Papa. This kōrero could be addressing Rongo who is outside of the whare of Matiti. Tikao says Rongo ki waho is a saying that means out in space;
 Matatahi mai te ara o tu manuhiri tua-rangi kei tawhiti – signaling a remote/sacred journey or pathway of a special occasion or event that is far away – it could be the arrival of a child through the birth canal;
 Kai te waro te kai – waro is a deep sea fish that Maui used to fish up the North Island. This could refer to the fish consuming the land luring to Maui's hook (Beatties, 1990, p. 26).

Tikao struggled to translate this creation karakia and admitted his frustration on not being able to “unveil its full meaning”, but he was taught this karakia as a young boy, the true meaning and depth perhaps naively eluded him (Beattie, 1990).

On Ruapuke Island off the Southern end of Aotearoa, a German Missionary, JFH Wohlers, collected mythical stories in the mid-nineteenth century. Unfortunately, Wohlers did not collect the names of his informants, instead referring to the people who shared stories with him as “old wise people” (Wohlers, 1895, p.128). Ruapuke Island at this time, although comparatively tiny and isolated geographically, catered well to

those who sought solitude away from conflict and confrontation among feuding hapū and iwi. Te Maire Tau (Personal Communication, March 2017) said that the people on Ruapuke originally came from Kaiapoi, escaping the Ngāti Toa raids. Tremewan (2002) included Wohler's writings in her collection of Southern Māori stories for her book, *Traditional Stories from Southern New Zealand*.

The story of most interest gathered by Wohler, was Tūtaka-hinahina (light dawns in a dark world). According to Tremewan, this is a story from Southern Aotearoa. Wohler had two versions and both stories have similar ideas running through them. In the first version, Tūtaka-hinahina dies, the whole world is plunged into blackness and people are not able to see anything. His only son, Te Roiroi-whenua, hears his father calling, directing him to his burial place. Te Roiroi-whenua finds two maggots, one male and one female. He cooks the male and leaves the female and as soon as he does that the light appears, and people rejoice and are able to carry on with their normal lives. The second version of this story is also about Tūtaka dying but before he dies, he tells the people to gather firewood and food. Upon his death, three beings stop the sun and throws the earth into darkness. The people die once their firewood and food runs out. The son of Tūtaka-hinahina, Te Roiroi-whenua, and his whānau survive due to having the largest supply of firewood and food. However, after burning his sacred fence, two maggots appear, he lights an oven and Tama-tea arrives, bringing the light and taking away the darkness. The exchange from the world of darkness to a world of light has been synonymous with creation stories all over Polynesia. Moving from one world to the next and highlighting that binary opposites can create potential and change in either their arrival or their departure (Tremewan, 2002; Wohler, 1895).

In Wohler's 1850 manuscript, he wrote about Murihiku creation mythology, which centered on Tāne, the child of Rakinui and Papatūānuku. Tāne was directed by Papatūānuku (the Earth Mother) to create a female form using the uha (femininity) from her own female being. He mated with this female form, and they had a daughter called Hine-atauirā. Tāne then made Hine-atauirā his wife and later went to visit his brother Rehua on the tenth heaven. He refused to eat cooked birds but requested live birds to take home. When he arrived home, Hine-atauirā had gone to the underworld. Tāne followed her, but was warned by Hine-atauirā to return to the world of the living to look after their children. Hine-atauirā would proceed to draw her children to the underworld. When Tāne returned out of respect and love for his parents, he acquired

some stars and constellations. Tāne dressed Rakinui with stars and his mother Papatūānuku with trees. Rakinui then directed his sons to dwell upon the earth to care for their mother (Wohler, 2001).

Tremewan (2002) states that the stories provided by Wohler, Matiaha Tiramōrehu and other Southern informants surmised that the work of Tāne led to the establishment of world order, with the sky above adorned with stars and planets and the earth below embellished with trees and food to feast upon. Human beings could now survive off the work of Tāne with the food in the forests that grow with the seasons, as foretold by the sky.

Teone Rena Rāwiri Te Māmāru of Moeraki sent his learning about creation to Edward Tregear in 1893. Te Māmāru's creation narrative also told of Takaroa and Rakinui's fight after Takaroa found out Rakinui had been sleeping with Papatūānuku whilst Takaroa was away burying their child's pito (umbilical remnant). Te Māmāru spoke also of Tāne creating the first two beings, Tiki and Io (a woman) out of earth (Te Māmāru, 1894:9-15). All accounts of the creation stories from different informants tell the story of whakapapa (layering of generations or layers) or world order. Regardless of the characters portrayed within, the stories reiterate the key components that include: a source root or seed that is germinated and nurtured to then grow and emerge into a life form that will eventually die in order for the lifecycle to begin again.

One of the many challenges with this section of the literature review was understanding the varying discussion about Io (the supreme being). Some of the Io deliberations challenged the legitimacy of Io within creation mythology as Christianised and elevated. This next discussion further explains the Io debate.

Io

Tikao states that Io is the Supreme Being, seen as the highest of Atua and that it was Io who directed the creation of the world from a state of sea and sand banks. Io Matua Kore pulled from the sea Papatūānuku and Rakinui. This following karakia was included into Herries Beattie's book, *Tikao Talks* (1990), published originally in 1939, twelve years after Tikao passed away. *Tikao Talks* contains knowledge and stories

imparted to Beattie by Tikao over a course of interviews in 1920. This creation karakia featured in the opening pages of this book:

Ko Io-whakatata, Ko Io-whatamai
Ko Hekeheke-i-nuku, Ko Hekeheke-i-papa
Ko Te Korekore ka ahu mai ka Pō-takiwā
Nō ka Pō-takiwa ka ahu mai ka Ao katoa
Ka puta ki waho, ki roto i tēnei ao mārama
He takata hou ki te whaiao, ki te ao mārama
Tihei mauri ora

It translates approximately as the following:

Io who is approaching, Io who appears
Descending to earth, to Papatūānuku
From the nothingness, to the time of darkness
From the darkness towards the beginnings of all worlds
Coming out, into this world of light
Is a new person into the daylight, into the world of light
The breath of life

Tikao, although a christian himself, clearly articulates in his interviews that the karakia he has shared have been taught through the ancient houses of learning (Beattie, 1990). These karakia validate Io as a creator and were present before the influence of Christianity. However, it is also debated by Buck (1949), Tau (2003), Shirres (1997) and Schrempp (1992) that the concept of Io was strongly influenced by Christianity in the first half of the 19th century, Christianity, they said had a profound effect on the authenticity of the Io creation traditions. This tension is evident in Buck's (1949) negative critique of the Io writings within Smith's (1899) manuscripts of Ngāti Kahungunu tohunga Matorohanga. Given the growing Ringatū and Hauhau faith in Māori communities at this time, the status of Io was heavily questioned by critics. They openly scorned that the rank of Io was elevated to that of Supreme God in order to compete and assimilate Māori religion to the Christian faith. The crux of the criticism was that the elevation of Io seemed aligned to the Bible's Genesis story and Tau (2003) questioned: "To what extent were Ngāi Tahu creation traditions influenced by Whatahoro's Io Matua Kore?" (2003, p. 59).

The evidence in the literature by Thornton (1999), Māori Marsden (2003) and Tikao is convincing that Io existed prior to the introduction of Christianity and held a place as a supreme atua (Beattie, 1990). Marsden (2003) states that Io existed at the beginning of

all things within the realm of Te Korekore; Io, according to Marsden, represented the realm of potential (2003). Agatha Thornton (1999) studied the writings of Ngāti Kahungunu scholar Hoani Te Whatahoro, who similarly publicly announced that Io was the supreme atua of all other atua:

Ko Io-te-wānanga o ngā rangi ia te pūtaka o ngā mea katoa; nana te wairua o ngā mea katoa, nana te ora o ngā mea katoa.

Io the all wise of the heavens is the origin of all things; it is the spirit of everything, it is the life of everything (1913, p. 14).

Moihi Te Mātorohanga and Nepia Pohuhu (1999), and a collective of kaumātua from the Wairarapa and further afield, decided to write down an extensive collection of ancient Wairarapa oral traditions. A number of issues in New Zealand at the time influenced the need to reposit knowledge in a written form, including the arrival of written language with the Europeans and a growing number of Māori literate in both English and Māori.

In the mid 1850s, different Māori religions were establishing themselves around New Zealand, and the popularity of Christianity was also gathering strength amongst Māori communities. It was felt by Mātorohanga and Pohuhu that it was time to record oral traditions down on paper to counteract the many mistruths they felt were circling and to ensure that their knowledge of the oral traditions taught to them was not misconstrued or misinterpreted by anyone (Thornton, 1999).

They selected Hoani Te Whatahoro to be the scribe of these two wānanga in 1860 and again in 1880. Te Whatahoro wrote down what was said and then kept the manuscripts of these wānanga hidden. In 1907, Te Whatahoro deposited the manuscripts into the Alexander Turnbull Library, where Percy Smith published passages in his book, *The Lore of the Whare Wānanga* (1913). Upon the release of this book, critics doubted the ability of Te Whatahoro to scribe accurately. Both Māori and Pākehā historians and academics raised the fact that Te Mātorohanga and Pōhūhū were Christians and their faith had a strong influence over the expression and recording of the oral traditions; especially the contentious issue that Io was the Supreme God. Many Māori had never heard about some of the knowledge Te Whatahoro described from these wānanga and challenged the reliability of the data.

Four manuscripts were gathered from the hui and the issue that led to the contention over Te Whatahoro's ability to scribe was that in each of the manuscripts the creation story was scripted. However, in each manuscript the story is told differently. Thornton (1999) refuted the criticism by saying that, even though the versions differ, they share six motifs or main events. Thornton felt these should be viewed as convincing regarding the validity of these manuscripts rather than a point of contention.

At the first wānanga, in 1860, it was recorded that Io encompassed the living and the dead, giving a sense that Io was a space, a dwelling where all could gather and be gathered. Marsden (1997) states that Io's divinity of creation was through a recitation process that took place over 27 nights. The first layer was Te Korekore (the void), the second Te Kōwhai (the abyss), followed by Te Pō (the night). Within these platforms, Io implanted a seed in Te Kore that took these states of being into a state of existence. To enhance the growth of this seed, Io placed a mauri (life principle) and te hihiri described the energy created by the growth of the seed (elemental and pure energy). It is in this state of pure energy that the next layers of creation commenced. From an unconscious state (Te Mahara) to the conscious state (Te Whakāro), then knowledge and wisdom through Te Wānanga and Te Whē (the seed word) (Marsden, 1992).

Marsden (1992) explains that, through the process of hauora, Io breathes life into these states to create shape (Atamai), form (Āhua), time (Wā) and space (Te Ātea). It was through these vital steps of creation that a natural world came into being and at this point of creation that Ranginui (Sky Father; Marsden uses the Northern Māori dialect of 'ng') and Papatūānuku emerged to then begin the next stage of evolution, and the creation of their own offspring. Ranginui and Papatūānuku were acknowledged as the primal parents.

Thornton (1999) said many people will tell a story differently to each other, therefore the question is whether Te Whatahoro transcribed the versions differently through lack of ability, or because he heard them differently from the many kaumātua or because he added his own knowledge that created differences in the final manuscripts? Regardless, Thornton argues that given that the stories all contained commonality with a number of shared motifs, this alone should not discredit the existence and position of Io (Matua Kore). Thornton supports the oral traditions as expressed in these manuscripts as being

a reliable source of knowledge and history. Io Matua Kore, says Thornton, is not an invented god of the 1860s but is a Supreme God of Māori Religion (1999).

This raised an interesting point in creation narratives about the importance of the storyteller in conveying messages embedded within mythology. Te Maire Tau's doctoral thesis (1997) addressed the storyteller within mythology as the pivotal character in the transmission of mythological stories. The role of a storyteller is to infuse drama to a story by providing intrigue, suspense and the lure to hear every word spoken. Therefore, stories can have many versions, many layers and many contexts.

The art of storytelling

Across Indigenous knowledge systems, stories and storytelling are valued for maintaining cultural knowledge (Barnherdt & Oscar, 2008; Bryere, 2012; Cook, 2003; Hooper, 2002). Gonzales (2012) highlights that Indigenous knowledge systems value the role of stories and storytelling. She says storytelling is a medicinal practice that carries traditional knowledge which in turn promotes wellbeing through the reinforcement of identity. Dr Gregory Cajete, Tewa author and Professor at the University of New Mexico, described the "mythic mind" as a transmitter of psychological truths. He says that storytelling recovers personal and communal myths that he believes is a protective factor. Cajete says it is far better that Indigenous people speak their myths than running the risk of myths being distorting by others (Gonzales, 2012).

Tau (1997) said that the storyteller in mythology develops his script from a mythical foundation and then draws in religious metaphors, symbols and imagery to reflect their own values and beliefs from their communities. Therefore, mythology is superimposed upon historical events. The story of the rangatira of Ngāi Tuhaitara, Tū Ahuriri and his search to find his father is an example of an embellished myth and an historical event. Tū Ahuriri's story directs the audience to two possible fathers, yet, if given a Ngāi Tahu lens, the symbols presented identify Tū Ahuriri's real father as Te Aohikuraki. It was when Te Aohikuraki's name was uttered that Tū Ahuriri was birthed after a prolonged and difficult labour. It was Tū Ahuriri's mother, Rakaitekura, that said to Tū Ahuriri he

would find his father “kei te toanga o te ra e noho ana” which translates as “at the setting of the sun” (Tau, 1997, p. 186). According to Tau, this saying is a common metaphor for death and therefore indicates Tū Ahuriri’s father was dead, whereas Tumaro, the first husband of Rakaitekura, was still living at this time. Another clue was the name that Tumaro issued Tū Ahuriri at birth: Te Hikutawatawa o Te Aohikuraki. This name, according to Tau, translates as “the mackerel tail of Te Aohikuraki”. This meant that Tumaro saw this child metaphorically as the tail of a fish, which was perceived as less desirable and only fit for the lower-ranked members of the iwi to eat. Clearly indicating he thought little of this child that was not of his loins but of Te Aohikuraki (Tau, 2003).

The Ngāi Tahu pūrākau above is an example of how a mythical story can have layers upon layers and plots within plots. The story of Tū Ahuriri is about deceitfulness, infidelity, love, loss, revenge, childbirth, customs and lore. It is an emotive account of a true historical event. This story was shared with me by a number of people as an example of a childbirth pūrākau. Their memory of this pūrākau was more about the difficult birth that Rakaitekura had to endure than the wider context of disloyalty and consequence. Tau (2016) surmised that mythical stories appear to follow common themes consisting of an illegitimate child or virginal birth, a person with super strength, god-like ability, and mental aptitude to overcome diversity. These stories also act as reminders that if people act badly, such as with infidelity or tapu infringement, there will be consequences and therefore to pay heed to the messages within the pūrākau for self-preservation.

Ngāi Tahu Creation Rituals

John White’s, *The Ancient History of the Māori*, highlights the alignment between myth and ritual (1887). White stated that pūrākau and kawa (Marae protocol) operate together so can only be understood when seen as one. Ritual or tikanga practices are described as bringing mythology to life by acting out the ritual (Armstrong, 2005; Campbell, 1972; Rappaport, 1999). Ritualistic ceremonies continue to keep the mind harmonised with the body, our surroundings and an awareness of our cultural place within a larger system. Campbell (1972) noted a change in the usage of ritual in all societies. Previously, ritual was used in every social occasion, maintained often through religion.

Over time, ritual became carried less by religion and only applied at very special occasions, yet ritual still remains; it is therefore not dependent on religion for survival (Armstrong, 2005; Marsden, 1992, 2003; Rapport, 1999; Smith, 1998).

The importance of ritual, according to Campbell, is teaching the young about their social and natural environment; he describes ritual as giving form to human life. When babies are born, they are unlike other species. The human central nervous system is open to receive imprinting from within the society they grow in. These etchings of life skills and cultural values are transmitted, alongside parental teaching, through the expression of ritualistic practices (Campbell, 1972).

Gonzales (2012) says that rituals, which she prefers to term “ceremonies”, bring knowledge into action and act as a bridge to ensure ancient knowledge is never forgotten. Rituals can also be a protective mechanism that allows a transcendence of linear time and transportation spiritually to the original time that the stories happened. An example of a ritual is waiata (songs or singing) as a birthing ritual and practice. Oriori or pōpō are known as lullabies that were sung throughout the pregnancy but more often at the birth of a high-ranking child. It was noted in McClean and Orbell’s (2004) book on traditional Māori waiata that, similar to other Māori concepts, waiata text and music should not be viewed in isolation from each other. Difficulties in text can be resolved after connecting the music to it and establishing why and how the text was phrased as such. Examples of waiata used in ritual are discussed in more detail in chapter six on Ngāi Tahu traditional birthing practices.

2.3 Section Three – Te Iwi o Ngāi Tahu

Ngai Tahu Identity and History

Ngāi Tahu are the people who claim traditional mana whenua over the vast majority of Te Waipounamu, the South Island of New Zealand. The origins of our tribe lie in the North Island, and before that in the islands of Eastern Polynesia (O'Regan, 2014, p. 11).

It is understood through archaeological evidence that there were people in Te Waipounamu six to seven hundred years ago. That is the extent of what is known about these earlier inhabitants. Atholl Anderson (1990) wrote that Waitaha arrived in the 13th to 14th century and were of Eastern Polynesian decent. In the oral accounts, Waitaha appeared to be the earliest southern tribe. The Waitaha people are acknowledged for the establishment of the southern whakapapa through the arrival of Rākaihautu and his son Rokohuia on the Uruao waka. These ancestors named many southern places, coastlines and significant landmarks (O'Regan, 2014).

The second stream of Māori that ventured south, approximately 20 generations ago, were Ngāti Māmoe from the east coast of the North Island. They descended from an ancestress by the name of Whatua Māmoe; they built two pā (fortified villages) in the Napier area, called Ōtatara and Heipipi (O'Regan, 2014). Further North in the Gisborne area, descendants of the Cook Island tupuna Paikea and his brother Irakaiputahi initiated more sub-tribal clusters. Other Kurahaupo waka (an ocean voyager canoe associated with bringing Māori to Aotearoa) groups formed between Gisborne and Napier, and were located along the edge of Raukawa Moana (Cook Strait). These groups were soon lured south due to more food sources, more land, tribal marriages and peace. By the mid to late 16th century through the 17th century, many of these East Coast groups had crossed the Cook Strait to Wairau, eventually making their way throughout the South Island. The larger tribal collectives were Kāti Kuri and Kāti Tūhaitara, who settled in the Kaikoura, North Canterbury and Banks Peninsula areas (O'Regan, 2014, p.15). Kāti Kuri stopped at Kaikoura and Kāti Tūhaitara covered southwards to Canterbury and Banks Peninsula.

Another important whakapapa connection for Ngāi Tahu came from Paikea's youngest son, Tahu Pōtiki, from the East Coast of the North Island around the 15th century. Tahu

Pōtiki married Hemo-ki-te-raki (his sister-in-law) upon the death of his brother Whatiua-te-ramarama. Tahu Pōtiki's nephew, Porouraki, was born from Hemo-ki-te-raki and Whatiua-te-ramarama. It is from Porouraki that the Ngāti Porou line descends. A branch from the Ngāti Porou iwi broke away and ventured to the South Island and became the Ngāi Tahu Ngāti Porou limb (Tau and Anderson, 2008).

Te Maire Tau (2003) writes about Ngāti Ira as another prominent iwi to the whakapapa of Ngāi Tahu that journeyed alongside Ngāi Tahu and Ngāti Kahungunu from Tauranga to the Wairarapa. Tau stated that Ngāti Ira descend from the son of Tura named Iratūroto. Tura was known to whakapapa to Ngāi Tahu, Ngāti Māmoe, Ngāti Ira and Ngāti Wairangi. Five generations after Iratūroto, the Ngāti Ira Rakatira Te Aomatarahi was mentioned in Ngāi Tahu stories alongside Tūhaitara. Te Aomatarahi also features prominently in the Ngāti Kahungunu traditions, and it is these stories that confirm the relationship between Te Aomatarahi and Ngāi Tahu.

Irakehu was the great-granddaughter of Iratūroto with a direct line from Ngāti Irakehu. She married Rakawahakura, who came from Tahu Pōtiki. They had three tamariki and from these three children came the three prominent hapū of Ngāi Tahu: Tūhaitara from Rākaiwhakāta's daughter; Kurī from Maruhoua's son; and through Rakawahakura and Irakehu's great-grandson Tahumutu came Tūteāhuka, which according to Anderson and Tau (2008) later merged with Ngāti Tūhaitara and Ngāti Kurī. Their great-granddaughter further cemented the Ira and Tahu connections when Kūhāroa married Ngāti Ira rangatira Te Aomatarahi, as mentioned above. Kūhāroa and Te Aomatarahi had a son, Tiotio; his daughters had arranged marriages with Ngāi Tahu to further bond the whakapapa lines between Ngāi Tahu, Rangitāne and Ngāti Māmoe (Tau, 2003).

Today the Ngāti Ira iwi align to the Ngāti Kahungunu ki Wairarapa and, like Ngāi Tahu, a number of hapū collate around a central hapū or iwi and became known as that particular iwi. Ngāti Kahungunu ki Wairarapa is a conglomerate of Ngāti Kahungunu, Ngāi Tara, and smaller clusters from Rangatane and Ngāti Māmoe (Tau and Anderson, 2008). The tribal groupings under the mantle of Ngāi Tahu acknowledged their joint ancestral connection to the East Coast of the North Island Rakatira (chief) Tahu Pōtiki. Te Raki-ihia of Ngāti Māmoe and Te Hua-tapu-nui-o-Tū of Ngāi Tahu were facilitators in the unification of the tribal collectives.

Post the southern tribal truce came devastating raids by Ngāti Toa and the growing hunger for land purchase by Pākehā (Tau and Anderson, 2008). By the 1800s, the Ngāi Tahu population was estimated to be 20,000; dwelling in Kaikōura, the West Coast (Te Tai Poutini) and through to Rakiura and the southern islands off Bluff (O'Regan, 2014). The tribal boundaries for Ngāi Tahu extends from the Te Parinui o Whiti (the White Bluffs east of Wairau lagoons) to Kahuraki Point (on the West Coast north of Karamea) and includes some off-shore Islands, such as Ruapuke and Tītī Islands (O'Regan, 2014).

Pākehā sealers and whalers were the first to come into regular contact with Ngāi Tahu Māori around 1795 in the Murihiku area (Southland) (O'Regan, 2014). Many Ngāi Tahu women married the whalers, who predominantly came from England and Scotland and a lighter scattering of whalers from France and America. Naturally, the European culture was thus not unfamiliar to the Ngāi Tahu community before the Treaty signing. In the 1830s, the local Ngāi Tahu rangatira and their hapū were managing very successful harbour and supply industries to the whaling ships. They provided food and fiber goods as they came into port, and many Ngāi Tahu even worked on the ships (Te Rūnanga o Ngāi Tahu, 1996; States Services Commission, 2006).

The British missionaries assisted Māori to become more proficient with literacy skills, which consequently improved their business knowledge and practice (Anderson, 1998; Carrington, Tau & Anderson, 2008; Cormack & Orwin, 1997; States Services Commission, 2006). In the 1830s, the Pākehā population (estimated at around 200 in the North Island) was relatively small in comparison to the 100,000 strong estimated Māori population in Aotearoa at this time. However, in less than ten years the situation changed radically. By 1839, there was an estimated 2000 Pākehā in New Zealand, with over 30 whaling stations situated along our Coastlines (Esler, 2003) Kawharu, 1989; States Services Commission, 2004; Ministry of Culture and Heritage, 2014). New technologies, such as the musket and boats, became their saviour after the notorious and lethal Ngāti Toa raids annihilated kainga (villages) at Kaikōura, Kaiapoi and Akaroa in the late 1820s through to 1830s (O'Regan, 2014). However, the trading of muskets was not the only thing Ngāi Tahu began seeking; they also traded a number of goods and became reputable in this business. As the trading economy grew, the need to

develop a treaty to aid relationships amongst settlers and Māori, and to improve international trading avenues became apparent.

The United Tribes of New Zealand

In the 1830s, with an increase in trading out of local ports that involved many Southern hapū, the need for a New Zealand flag became advisable after an incident in Sydney. Australian custom officials seized a New Zealand-built boat when they were unable to produce identification documents (Beattie & Anderson, 1994; Luxton, 1998). British navigation laws dictated that every ship must have official certificates that provided details about the boat's construction, ownership and place of origin. Included in the identification requirements was a formal flag. Official British resident James Busby wrote to the New South Wales Colonial Secretary asking for the adoption of a New Zealand flag. This appeared to be accepted as flag designs were produced and, in 1834, twenty-five far north chiefs came to Busby's home in Waitangi and alongside other government officials voted on a flag. King William IV gave his approval of the flag that became known as the Flag of the United Tribes of New Zealand (Beattie & Anderson, 1994; Luxton, 1998).

James Busby utilised the Chief's camaraderie after the flag achievement to gain momentum on governing issues for New Zealand. He was instrumental in the signing of the 1835 Declaration of Independence, which gave authority of the land over to the Chiefs who gathered under the collective banner of the United Tribes of New Zealand. Busby's intent was that the collective of Chiefs would meet annually at Waitangi and create laws that maintained the peace and order in the land and that they would be given protection by the British Government (Evison, 2006; King, 2003; O'Malley, 2016; Orange, 1987, 2004). Unfortunately, the United Tribes of New Zealand did not meet, as desired by Busby, and the formation of a New Zealand government did not eventuate at this time. Consequently, the Declaration of Independence did not gather the support required to create change within the disgruntled New Zealand setting at that particular time (Evison, 2006; King, 2003; O'Malley, 2016; Orange, 1987, 2004; State Services Commission, 2006). The British Government felt that firm political action was needed around the zealous acquisition of Māori land by the New Zealand Company to entice British subjects to settle in New Zealand. The second area of government concern was

the increasing disorder and rising tension between Māori and the British settlers. The introduction of British law was believed to be the right intervention to create harmony amongst all (State Services Commission, 2006).

Ngāi Tahu relations with Pākehā in the 1820s

Both O'Regan and Anderson talked about the importance of strategic marriages to the political structure of Ngāi Tahu. They state, given the vast geographical terrain of the South Island, arranged marriages uniting the many hapū fractions under the mantle of Ngāi Tahu was crucial to the survival and unity of the iwi. Therefore, in the 1820s, arranged marriages between the Pākehā settlers and the daughters of chiefs and others from high-ranking families was not uncommon (Anderson, 1980; O'Regan, 1987). It had been noted in publications by Tipene O'Regan (1997, 2014), Harry Evison (1988, 1997) and Atholl Anderson (1990) that in the 1830s Ngāi Tahu had already had extensive involvement with Pākehā and Ngāi Tahu were familiar with trade and building bicultural relationships. In particular areas, such as Ōtākou and Murihiku, they were equipped with European technologies, including muskets and whaleboats (Kawharu, 1989).

Not only were many hapū of Ngāi Tahu familiar with Pākehā provisions, the return of Ngāi Tahu prisoners from Ngāti Toa after their conversion to Christianity influenced other Ngāi Tahu to this European faith. Two weeks prior to the arrival of the Treaty of Waitangi in the South Island, the first Christian missionary was established in Waikouaiti under James Watkin. Harry Evison's (1988) book, *The Treaty of Waitangi and the Ngāi Tahu Claim*, noted that Watkin managed to enlist prominent Ngāi Tahu elders such as Matiaha Tiramōrehu from Ngāti Tūāhuriri and Horomona Pohio from Ngāti Huirapa to his mission. Missionaries created camaraderie through faith, which often led to land transactions with many missionaries owning large pieces of Ngāi Tahu land.

Early Ngāi Tahu population demographics

The Ngāi Tahu Petition in 1874 was described by Chief Judge Fenton to the Māori Land Court as the petition by the Natives to the House of Parliament in Wellington highlighting the wrongs in the Kemp purchase over the non-return of one acre for every ten acres sold. The Petition portrayed the situation for Ngāi Tahu as only just keeping themselves above the line of pauperism through shared grit and resilience. Many missionary and European tradesmen debated just how Ngāi Tahu could keep their show of strength up. By 1891, the toll of poverty was beginning to show in the numbers of Ngāi Tahu who were landless, and the tribal structure was beginning to crumble as Ngāi Tahu were forced to move away from the allocated land reserves to seek better economic opportunities. Hori Taiaroa mentioned in 1881 that there were 28 Ngāi Tahu settlements in the Ngāi Tahu tribal boundary, but by 1890 there were nine (Evison, 1988).

Atholl Anderson gave an insightful lecture as part of the Hocken Lecture series in 1990 addressing the evolution of the ethnicity among early Māori-Pākehā families in the Southern region of the South Island. In Anderson's paper, *Race Against Time*, he utilised data gathered by June McDougall from the New Zealand Genealogist Society to emphasise his findings. McDougall obtained information about the early European males, and their partners of different ethnicity and their children, who either spent time in the Otago and Southland region prior to 1848. McDougall's data from historical observations and census material allowed Anderson to surmise that the first intake of men into New Zealand between 1780 and 1848 were predominantly single English men, the Scots and Irish came later, then Australians and Americans between 1848 and 1860.

Children of Māori and Pākehā heritage were noted in the Southern region in the 1820s. Anderson (1990) claims that the data suggests that Māori women were in their teen years when they had their first child to their Pākehā partners. The earlier relationships

appeared to be arranged between the daughters of chiefs and European settlers, some for novelty value and others to enrich the tribal resources with European technologies and better their trade opportunities. The extinction of the right whale from the Southern Hemisphere led to the decline of the whaling industry around the mid 1840s. The European and blended ethnicity populations were growing quickly in the southern region of New Zealand. This was in stark contrast to the steady decline for the overall Māori population (Anderson, 1990).

The blended ethnic children were referred to as 'half-caste' and, it was noted by Anderson (1990), that when 'half-caste' children became old enough to partner, the women were marrying European husbands. Not only were the half-caste populations higher in the South Island than the North Island, but the other significant difference was that in the North Island the European males partnering with Māori or half-caste Māori were often locating themselves in the Māori settlements. Therefore, the maintenance of tribal tikanga and values for the Northern half-caste Māori remained strong. The South Island half-caste Māori wives were choosing to live with their Pākehā husbands away from their kaika (village). The rate of assimilation appeared to occur faster in the South Island due to a larger half-caste population and the movement away from their cultural knowledge base (Anderson, 1990).

In terms of the birthing rates in the South Island, Anderson (1990) argues that the high child mortality reported in the 19th century was not what he found in the data. He agrees that the data indicated that Māori women who partnered with the original European settlers still died younger than their European counterparts, but their children often survived them. It appears that the children of these couplings did grow to become adults and that the European settlers often did not re-partner with a full-blooded Māori but tended to partner with either a European woman or a Māori woman of blended ethnicity.

In second marriages more offspring were produced, with an average of ten children per relationship. Anderson doubts the accuracy of blended ethnic children to European fathers, as it was also thought that some fathers did not acknowledge their patronage. Also, he wrote that Māori women would on occasion gift their children to relatives to raise in order to maintain their relationship with their European partner. In the 1886

New Zealand Census, it was recorded that over 50 percent of the Māori population were of blended ethnicity in the South Island and predominantly from the Southland region (Anderson, 1990). Many European historians and politicians deliberated that it was only a matter of time before the Māori population died out, even with the growth of the half-caste Māori community this was deemed not enough to turn around the population decline.

At the turn of the 20th century, the Māori population began to rise due to the improvement in health and living standards. Doctor and politician Te Rangi Hiroa disputes that the statistics portrayed an accurate picture of the blended ethnic populations in New Zealand and Hiroa undertook his own research. He gathered data on Māori ethnicities in the Māori Battalion and native schools. Hiroa's research showed closer to 50 percent of the Māori population in New Zealand were of mixed heritage, not 12.7 percent as stated in the 1916 Census (Anderson, 1990). Anderson reports that between 1926 and 1961 census surveys asked the public to simply tick if they were Māori or not, no further refinement of this questions was required. Therefore, it was of note that many chose to tick that they were full-blooded Māori even though many were, in fact, children of mixed heritage. This may show that the figures are indicative of what demographer Professor Ian Pool said in his book, *The Māori Population of New Zealand 1769-1971*, that people were opting for “sentimental over biological reasons for choice” and Anderson agreed that the “census category *full* Māori has been grossly over-enumerated” (p. 18).

Te Tiriti o Waitangi – Treaty of Waitangi

Te Tiriti o Waitangi came into effect after the House of Lords conducted a special enquiry in 1838. They reviewed the land transactions in New Zealand and could see the potential for further violence and destruction between Māori and Pākehā if a treaty was not put into place. Yet, the completed Te Tiriti o Waitangi clearly kept the power with the Crown by enforcing all land transactions to take place through the Crown. Te Tiriti o Waitangi dictated that settlers could no longer purchase land directly from Māori, nor could Māori sell their lands directly to the settlers (Evison, 2006; King, 2003; O'Malley, 2016; Orange, 1987, 2004). Historian Harry Evison (1988, 2006) and Ngāi

Tahu historian Te Maire Tau believe that Ngāi Tahu thought that Te Tiriti o Waitangi would bring real benefits to the iwi. The facilitation of land purchases via the Crown appealed to Māori. Ngāi Tahu realised that having a third-party assist with the processing of large land transactions was of benefit to all. However, Ngāi Tahu's trust in the Crown's mutual advocacy was betrayed shortly after the signing of Te Tiriti o Waitangi (Evison, 1997).

Evison (1997) highlights the state of the Ngāi Tahu iwi at the time of Te Tiriti o Waitangi, stemming from the 1820s and inter-hapū battles. The impact Ngāti Toa had on Ngāi Tahu in the late 1820s, with Te Rauparaha leading the plundering of kāika and capturing of slaves; and the ravishing epidemics of European diseases, such as influenza and measles, was devastating. Ngāi Tahu had no protection from the diseases nor guns to match the northern iwi. These crises led to the population of Ngāi Tahu in the 1830s to be under 2500 (Anderson & Tau, 2008; Evison, 1988). Te Tiriti o Waitangi came at a time of hardship. Ngāi Tahu understood Article Two of Te Tiriti would guarantee their chieftainship over their land and other valuable possessions, offering a light at the end of an enduring tunnel that they believed promised peace and protection (Evison, 1988).

Over 500 Māori Chiefs between February and September of 1840 signed Te Tiriti o Waitangi. Major Bunbury was in charge of the signing in the South Island, and alongside him came missionaries Edward and Henry Williams as interpreters. They took the Māori version of Te Tiriti o Waitangi and traveled to Akaroa on May 30th, 1840, and gained signatures from Iwakau and John Puiraki Tikao. Bunbury and the Williamses went onto Stewart Island and Ruapuke for signings from three more chiefs, including Tūhawaiki on June 10th, then to Ōtākou on June 13th to collect Karetai and Korako's signatures. Bunbury collected a total of seven Ngāi Tahu signatures and then sailed to Cloudy Bay. Here, he gathered more signatures from northern chiefs before he announced British sovereignty over the South Island (Evison, 1988).

In the report, *The Colonising Environment: An Aetiology of the Trauma of Settler Colonisation and Land Alienation on Ngāi Tahu Whānau*, the authors Reid, Rout, Tau and Smith (2017) state that the period between 1840–1890 in New Zealand was one that completely changed the dynamics and power balance, with devastating effects on

all Māori tribes. With 500,000 settlers arriving in New Zealand throughout this period, the population demographics weighed heavily in favour of the settlers, with ten settlers to one Māori. By 1863, only 23 years after the signing of Te Tiriti o Waitangi, over 85 per cent of Ngāi Tahu land was in the possession of the Crown. Legal historian Stuart Banner (2000) says that the land legislation by the settler government at this time overwhelmingly favoured the settler. Banner states that the Crown did this by adjusting the laws that dictated the land market in ways that meant that Māori would always receive the lower end of the deal. Banner argued that the laws at this time in New Zealand history governed who could purchase, who could sell the land, and who paid the greater land market administration fees. Banner termed it ‘Conquest by Contract’; this led to Ngāi Tahu being deprived of their land and resources and leaving many tribal members in a state of poverty and vulnerable to disease (p. 47). Reid et al. (2017) claim that material poverty and disease are core components of what they termed Māori historical trauma. They emphasised how land alienation had also facilitated the loss of political autonomy, as Māori were no longer authoritarians of the land once the Crown took over the title.

Ngāi Tahu first headed to the Courts to plead their case in 1868, only to be blocked by the government passing legislation that denied any hearing or rulings by the courts on the case. The second attempt to prove the grievances associated with the land purchases in the Canterbury, Akaroa, Otago and Murihiku areas came when Governor Grey appointed Thomas Smith of the Native Land Court and Francis Nairn to lead a Commission of Inquiry, the *Smith-Nairn Commission* (1879). A change of government impeded findings from this inquiry being publicly released when they withdrew the Royal Commission funding. The third investigation to seek redress took place in 1886, with a Royal Commission into the land sales. This Commission found similar results as the Smith-Nairn Inquiry (1879) and gathered evidence of neglect towards Māori and wrongful transactions by the Crown. A change in government leadership at this time contributed to a lack of action or change for Māori.

Ngāi Tahu were relentless in their determination to have their case heard and retribution given. Commissioner Mackay commenced another Royal Commission, the *Middle Island Natives Claim*, in 1891. Mackay visited Ngāi Tahu Rūnanga in the Canterbury and Otago provinces; his intent was no different to the previous inquiries. Mackay’s

directive was to seek the names and numbers of the natives who had been awarded reserves, and to see whether the land set aside for them was adequate in meeting their needs for economic and social wellbeing. Hoani Matiu's summation of the inquiry on the 2nd of March 1891 at the meeting in Waikouauti. He reflected the feelings of many Ngāi Tahu who attended these meetings around the South Island. Hoani sternly retorted that the government knew very well what the grievances were regarding the need and demand of Ngāi Tahu in terms of land settlements, but the government intentionally and continually postponed any discussions or negotiations. He exclaimed:

This inquiry was yet another counting exercise to ascertain how long it would be before the natives were extinct of which time it would no longer become an issue for the government to attend (AJHR, 1891, G7, 370).

Mackay acknowledged that he found through his inquiry that many of the old native people whom the government had ceded land to had died. The many men who commenced the land claims and had played such vital roles in the settlement process were no longer alive. Throughout the Rūnanga meetings, Mackay found similar concerns about the acreage being insufficient for the natives to make a living off, and the allotted Crown land was often remotely located. The distance made it difficult to obtain labourers to work the land and the value of the land was also poorly influenced by the small size and difficult location. Before the Treaty of Waitangi, Ngāi Tahu were able to graze animals on their lands, however, post-Treaty the grazing of animals on tiny allotted acreages was nigh impossible. It was also realised that the land allocated was not suitable for planting crops or pastoral use. Māori needed more knowledge on how to farm different crops on often hillside plots smothered in bush and sometimes the land was infertile to begin with (AJHR, 1891).

A common scenario Mackay (1891) witnessed at many of the reserves, were that the young Ngāi Tahu men worked in sharing gangs or did harvest work on Pākehā farms in order to provide extra income for their whānau on reserves. However, a lot of what the young men earned went straight back into paying off the tradesmen or the storekeepers for previous incurred debts. Whānau on the reserves with allocated pieces of land struggled to cultivate crops large enough to be financially beneficial. Most of the land allotments were only big enough to cultivate food for the whānau. Mackay

noted alongside many other key representatives from the Rūnanga, such as Tieke Kona, that the Māori on the Taieri had it tough due to the land being so ‘inferior’ that very little could be done with it. To add to the Taieri plight, was their inability to eel in the River Taieri due to the stocking of trout with the nearest lagoon being hemmed in by European industries. Therefore, access to hapū (sub-tribes) food resources was restricted and contributed to the overall challenge of land alienation ((AJHR, 1891, G7, 370, p. 36). Constraints to traditional food sites were also noted in Tipene O’Regan’s chapter in Sir Hugh Kawharu’s 1989 publication, *Waitangi – Māori and Pākehā Perspectives of the Treaty of Waitangi*, as having a huge emotional and economic impact post-Te Tiriti o Waitangi. He describes access to mahinga kai (traditional food resources) for consumption and trade as crucial component to the “social fabrication of a tribe and inter-tribal life” (p. 253).

Another challenging condition highlighted during the 1891 enquiry by almost all of the Rūnanga representatives, and those attending the regional meetings, was the lack of medical provision in all areas. The medical costs to see the doctor, with additional fees for medication prescriptions and the expense of travel, meant people were not seeking medical attention. This then further exacerbated illnesses and Māori were dying with no access to treatment (Durie, 1994, 2001; Gluckman, 1972; Harte, 2001; Reid et al., 2017). Epiha Maaka from Moeraki said he had to make a difficult choice when both his son and wife became ill. He took his son to the doctors and then treated his wife with rongoā Māori (Māori medicines). The medical expenses meant they could only afford for one to be seen by the doctor (Mackay, 1891).

Alongside the broken promises the government made regarding hospital and medical provision for Ngāi Tahu, the government also assured that Ngāi Tahu would get access to education. Hare Kahu said that Temuka had no native school and although his children could attend the European school, the vibe in the Māori community was that native children were not welcome. A news story published in the Temuka Leader in 1890 made reference to the view that Māori were dirty and used the word “unfavourably”. Māori whānau were anxious about sending their children to the school for fear of discrimination from staff and the school community (Mackay, 1891, p. 50).

The 1911 Royal Commission on the Kaiapoi Reserve (land set aside for Māori near Christchurch) was collated and written by J.F. Andrews. The report highlighted what historian and author Richard Hill (2004) describes in his book, *State Authority, Indigenous Autonomy Crown-Māori Relations in New Zealand 1900-1950*, as an example of how the Crown and its agents constantly managed to “defuse or deflect” most demands from Māori for autonomy, and the righting of wrong doings over land purchasing and reserves. Hill says that in the first half of the twentieth century the government possessed the ultimate power and used this authority to meet its own political needs, with little attention to the rights of Māori, unless it suited the government’s position at that time. Hill alleges that this was because of New Zealand, as small as it was, still coming under “global imperialism” that specialised in “socio-racial control and assimilation” (p. 266).

The Kaiapoi Reserve included 2640 acres of land, which was subsequently subdivided into sections and granted by the Crown to individual owners. The Supreme Court enforced a will system for land title succession and maintained ultimate control through the endorsing of land via wills. Discrepancies over valid and invalid wills arose, as some beneficiaries were unable to access land that should have been rightfully handed over to them within the will system. The conflict between using a European system, such as the will, over a Māori land succession process defined by whakapapa and ahikā (title of land through continuous occupation) led to the Kaiapoi Reserve commission inquiry (AJHR, 1911, G-05). This inquiry illustrated a frustrating battle between judicial bodies providing misinformation and misguidance over the establishment of wills, and the authorisation of these wills in regard to the sections of the Kaiapoi reserve (AJHR, 1911, G-05). This is another example of suppressing the rights of Ngāi Tahu to apply their own cultural systems over their lands, including the right for wāhine Ngāi Tahu to have land ownership through succession as outlined below.

Tikao made a statement in this inquiry pertaining to the legality of wills, where he pointed out that Sir Walter Buller conducted the division of the Kaiapoi reserve in 1861; he arranged the allotments to be shared equally between husbands and wives. However, when the details of the allotments were drawn up and handed over to Tūāhiwi between 1864 and 1865, the wives were left off the ownership titles. Buller (1911) said that under English law the male was superior to his wife. The land could still be bequeathed

to the wives, but Buller suggested that they make their wills the European way so that they could leave their property to whom they wish not as they did traditionally through whakapapa ties and natural imparting of land to descendants (AJHR, 1911, G-05, pp.16-18).

The construction of European wills caused conflict and debate amongst Ngāi Tahu as they fought for wills to be sanctioned through the judicial services, as suggested by government officials. Ngāi Tahu met with law changes and indecision over which authority could give permission over the wills. This resulted in long, drawn out processes to resolve will opposition by individuals and collectives (AJHR, 1911, G-05, pp.16-18). Tikao (1911) stated that there was no consistency in whether wills were given probate or refused. Māori had minimal power to bequeath their sections within the Kaiapoi reserve. English wills were sold to Māori as progression simply by adopting a Pākehā process, but this ended up being another tool of disempowerment of divide and conquer. Tikao ended his statement in the Royal Commission by asking for attention to be given to the following areas:

- That the Māori form of bequeathing land via ōhākī (legacy) was the best way for Māori regarding Māori land.
- Government officials drafted the wills and were appointed to teach and guide Māori through a process. Yet, the ongoing issues were targeting Māori, not the government officials.
- Many wills had already been passed through the correct pathways by the Supreme and the Native Land Court but upon fulfillment the wills were being rejected and not granted (AJHR, 1911, G-05, pp.16-18).

Tikao asked, lastly, who would pay for these mistakes that were not the making of Māori but rather those of the government: “Who will own this expense?” Yet again, he proffered, it will be Māori who will bear the brunt of this cost in many ways and for many years to come (AJHR, 1911, G-05, pp.16-18). In terms of wāhine Ngāi Tahu, Paterson and Wanhalla (2017) discussed Māori land acquisition by Pākehā settlers as dismissing the voice of wāhine Māori. Tane Māori (Māori men) more often represented their whānau, hapū and iwi when negotiating with the colonial agents over the purchase

of land that was owned collectively by whānau, hapū and iwi. Wāhine Māori were also vocalising and writing their concerns and addressing issues over land sales by writing to government officials, yet their concerns were often ignored in the event of erroneous land purchases.

The Ngāi Tahu claim - Te Kerēme

In 1849, Matiaha Tiramōrehu commenced what was to become a very long-drawn-out land claim seeking retribution for the broken Te Tiriti o Waitangi promises between the Crown and Ngāi Tahu. Numerous petitions and submissions to Parliament, attempts at restoration through the Native Land Court and letters and visits to Queen Victoria to plead the Ngāi Tahu land grievances came to no avail. Hōri Taiaroa continued the Ngāi Tahu claim process in Parliament during the 1870s and over the following years numerous Ngāi Tahu leaders made multiple attempts to get the Ngāi Tahu injustices heard and addressed by the Crown.

The Ngāi Tahu Māori Trust Board was initially established in 1946 to distribute any Crown compensation monies from the Kemp Purchase in 1848. The Kemp Purchase relates to the land bought by land commissioner Harry Kemp on behalf of Governor Grey in 1848. Contentious issues surrounding the sale were raised by Ngāi Tahu signatories at the signing regarding the land reserves set aside in the purchase for Ngāi Tahu, including contentious food harvesting sites (mahinga kai). Ngāi Tahu concerns were validated when the Crown failed to deliver on its promises in the Kemp purchase of both adequate land reserves and access to mahinga kai sites (Evison, 2007; Mackay, 1873; AJHR, 1878, C-04).

The Board continued the hard work of previous Ngāi Tahu ancestors to claim retribution. Tribal historian Sir Tipene O'Regan says that the Ngāi Tahu claim differed to the many other claims previously put before the Waitangi Tribunal. This particular claim was an amalgamation of nine major claims, representing a vast geographical area, involving a variety of environmental factors. The plan to amalgamate all nine claims was not an ideal choice by Ngāi Tahu but was strategically influenced by a new law

that came into effect in 1986. The State-Owned Enterprise Act implied that all Crown assets would be transferred into State-Owned Enterprises, and therefore this meant the Crown was no longer the owner. O'Regan and Ngāi Tahu tribal members feared that the battle to claim back land entities individually could be much harder once this Act was passed (Kawharu, 1989). Therefore, the nine major land claims were presented as one under the title Te Kerēme (the claim) (Evison, 1988, Tau, 2012, TRONT, 2017).

Te Kerēme targeted the reserve land within the Ngāi Tahu tribal boundary. Ngāi Tahu maintained that the Crown used a tactic of buying large areas of land, inclusive of land reserves for Ngāi Tahu iwi members. However, this dishonest approach to purchasing land in its entirety with a promise to return reserved land to Ngāi Tahu following the completion of the transaction was neither reliable nor enforced once the Crown took ownership. The Crown, according to O'Regan, did not honour its Treaty obligation to protect the rights and possessions of Ngāi Tahu (Kawharu, 1989).

In 1989, the Ngāi Tahu Māori Trust Board constructed a new tribal structure and sent a submission to the Select Committee stating that the Board wanted one representative from each Ngāi Tahu Papatipu Rūnanga to form a Ngāi Tahu Iwi Authority to be known as Te Rūnanganui o Tahu. The new tribal structure would hold and manage the tribal assets and redistribute the settlement monies and assets back out to their members via the Papatipu Rūnanga (Evison, 1988; Kelly, 1991). The Ngāi Tahu Māori Trust Board would then become the Trustee manager to the assets. With the new governing structure ready to go, the Ngāi Tahu Māori Trust Board, under the direction of Tipene O'Regan, led the Crown negotiations on behalf of Ngāi Tahu and the Ngāi Tahu Māori Trust Board. The key claims under Te Kerēme included the following land purchases:

- Ōtākou, purchased in 1844 by the New Zealand Company and subsequent land transactions up to 1960 (Evison, 1988). This sale involved 162,000 hectares of land in Dunedin. The New Zealand Company in previous land transactions set aside land as “Native Reserves”, otherwise known as “tenths”. Although there was no actual mention of native reserves or tenths in the Ōtākou purchase, Ngāi Tahu assumed that the tenths would also be applied to this purchase (Evison, 1988; O'Regan, 1997; Waitangi Tribunal, 1991). Ngāi Tahu claimed that the

New Zealand Company's Chief Representative, Colonel William Wakefield, gave a verbal promise about the tenths (Evison, 1988).

- The Kemp Purchase concerned the Canterbury and Otago area. In June 1848, Commissioner Kemp came on behalf of Grey to carry out the land transaction. The land reserves promised to Ngāi Tahu by the Crown were not marked before they were signed, which had previously been done in land acquisition. Grey had instigated a new plan with the Kemp Purchase that involved the purchasing of the whole block and then providing the reserves after the sale. Post land sale, a map of the Kemp purchase was provided to Ngāi Tahu. The agreed boundaries from Maungatere near Kaiapoi south to Maungaatua had been significantly extended to include the West Coast and the offered reserves were much smaller than anticipated. Commissioner Mantell, who was given the task to set out the reserves, promised that the reserves would increase over time, Ngāi Tahu would get extra money and that the Crown would provide schools and hospitals for Ngāi Tahu. This did not happen, and all promises by Mantell were not delivered (Evison, 1993; O'Regan, 1997, 2017).
- The 1853 Murihiku purchase also involved Commissioner Mantell. This land deal included land purchased in the Southland area. This land purchase was a repeat of the grievances from the Kemp purchase, with denial of reserves and land reserves being too small. Ngāi Tahu did not include Fiordland in this particular land sale, but it ended up being in the land deed transaction without Ngāi Tahu's full consent. West of Wairau was another source of contention, as Ngāi Tahu claimed that it should not have been in the land sale either (Evison, 1988, 1993; Ngāi Tahu Māori Trust Board 1986; TRONT, 2017; Waitangi Tribunal, 1991).
- The Banks Peninsula was initially left off the Kemp Purchase in 1848 due to French whaling Captain Jean Langlois. He had been to Akaroa previously and had started negotiations over land. Upon Langlois's return from France to seek approval from his government to colonise the South Island, he arrived in Akaroa to discover that Britain had beat him to it with the Treaty of Waitangi in 1840.

Langlois could no longer purchase land directly from Māori. This may have stopped Langlois buying larger sections of land, but he still obtained some land from local Ngāi Tahu chiefs in Akaroa. The mood captured at the time between Ngāi Tahu and the French was perhaps more trusting than between Ngāi Tahu and the British. Ngāi Tahu were skeptical of the British involvement with their enemy Te Rauparaha after he hid onboard a British brig coming into Akaroa and attacked the hapū of Te Maiharanui in 1830. In 1849, the New Zealand Company managed to obtain the Banks Peninsula harbours for a Canterbury settlement by informing Ngāi Tahu that they breached Te Tiriti o Waitangi by offering the land to the French without going through the Crown agency. Commissioner Mantell said, although Ngāi Tahu were in the wrong, he would be considerate and offer Ngāi Tahu some reserves and a small payment for the lands. However, the lands set aside for Ngāi Tahu were not able to be farmed and this “consideration” from Mantell seemed to further their hardship (Evison, 1988, 1993; Ngāi Tahu Māori Trust Board 1986; TRONT, 2017; Waitangi Tribunal, 1991).

- The Arahura land purchase in 1860, according to O'Regan (1997), saw the Crown reneging on its Treaty obligations once again and making the reserved areas in the West Coast area perpetually leasehold land to all the gold diggers in the 1860s who were relishing in the opportunities of gold and land. Local Māori were forced to receive their rents from their lands via a Crown agent that also dictated how much rent the land would fetch and how often the local Māori would receive their rent (Kawharu, 1989).
- Ngāi Tahu never agreed to sell any land between Mawhera, Kotukuwhakaoho and the Hokitika rivers but that did not stop the government making promises and threats to Ngāi Tahu that forced them to sell the land with reserves. The whole of the Arahura riverbed and river mouths were set aside as reserved areas for Ngāi Tahu in the purchase. Legislative processes, such as the Westland and Nelson Native Reserves Act, once again eroded the reserves in 1887 and the implementation of 21-year leases controlled by the government commenced

(Evison, 1988, 1993; Ngāi Tahu Māori Trust Board, 1986; O'Regan, 1997; TRONT, 2017; Waitangi Tribunal, 1991).

Amongst the Waitangi Tribunal land claims from Ngāi Tahu, was the loss of access to mahinga kai sites (natural food sources). Anderson, Evison, O'Regan and Tau could not stress enough in their writings how vital these food resources were to the tribal economy and survival of Ngāi Tahu. These traditional food sites were considered by Ngāi Tahu to be guaranteed to Ngāi Tahu under Article Two in the Treaty of Waitangi which said Māori would continue to have their fisheries and natural food resources. Harry Evison (1988) states that the South Island in the 1840s was abundant with bird and fish life, both inland in the rivers and lakes and also off the coastal seas traversed in double hulled waka. All food sources were conserved to ensure the resource remained sustainable. Post the signing of Te Tiriti o Waitangi, many waterways that were once abundant and replenished have since been mismanaged, mistreated and pillaged. Ngāi Tahu's claim challenged the Crown to be part of the restoration of these resources as a Treaty obligation (Evison, 1988).

Te Kerēme was asking for 3.4 million acres of land back from the Crown. This was only one-tenth of what was initially sold to the Crown. Te Kerēme had at least 12 different commissions and inquiries, all of which could not refute the wrongdoings by the Crown to Ngāi Tahu (Te Rūnanga o Ngāi Tahu, 1996).

Over ten months, the Waitangi Tribunal met nine times with Ngāi Tahu. Starting at Tūāhiwi Marae on the 17th of August 1987 then venturing to Kaikoura, Christchurch, Taumutu, Arowhenua, Ōtākou, Dunedin, Bluff, Hokitika, and Greymouth. The Tribunal received 900 submissions. Some of these submissions were over 700 pages long. It was a lengthy and arduous process concluding with a comprehensive and lengthy report in 1991. It consisted of three volumes with a total of 1300 pages. The 1991 report was the first of three reports that recognised that the Crown had failed Ngāi Tahu and the Treaty. The Crown did not act in accordance with its Treaty obligations through the dishonest actions of the Crown representatives and the passing of legislation of greater benefit to the Pākehā to the detriment of Māori. Legislation, such as the South Island Landless Natives Act in 1906, The Native Reserves Act in 1856, Māori Reserved Land Act in 1955, and initiatives, such as the Protectors of Aborigines

in 1840 and The Native Land Purchasing Ordinance in 1841, all read as supportive campaigns to acknowledge the rights of Ngāi Tahu but in reality, these statutes further imposed rules and regulations that impeded the growth and wellbeing of Ngāi Tahu (1991, Waitangi Tribunal).

Ngāi Tahu's claim, Te Kerēme, eventually led to the Waitangi Tribunal releasing its findings and recommendations in 1991, and again in 1992, in response to Ngāi Tahu's fisheries claim. The final Waitangi Tribunal report was completed and presented in 1993. Ngāi Tahu aptly described the claim as the *Nine Tall Trees of Ngāi Tahu*. The first comments in the report sadly revealed the overall impression of the Waitangi Tribunal's findings,

The narrative that follows will not lie comfortably on the conscience of this nation, just as the outstanding grievances of Ngāi Tahu have for so long troubled that tribe and compelled them time and again to seek justice. The noble principle of justice, and close companion honour, are very much subject to question as this inquiry proceeds. Likewise, the other important equities of trust and good faith are called into account as a result of their breach sadly give rise to well-grounded iwi protestations about dishonour and injustice and their companions, high-handedness and arrogance (1991, p.11).

The extent of the grievance is felt when considering that New Zealand covers 66 million acres and, of this, approximately 34.5 million acres passed from Ngāi Tahu tenure to the Crown for the sum of 14,750 pounds.

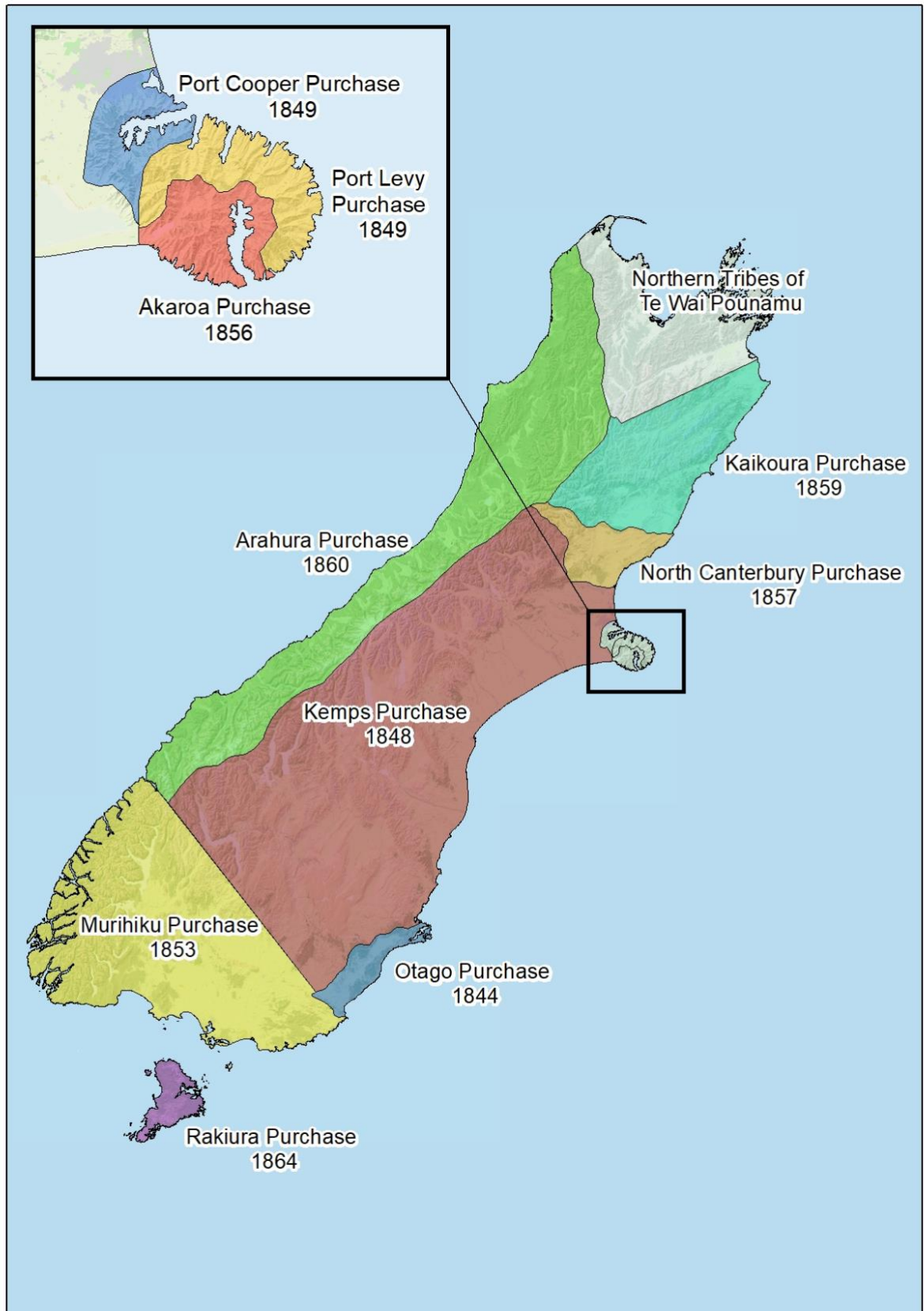


Fig. 2. Ngāi Tahu land purchases between 1844–1864, Te Rūnanga o Ngāi Tahu

The Ngāi Tahu new governing structure was ratified under the Te Rūnanga o Ngāi Tahu Act in 1996 and one year later the Ngāi Tahu Deed of Settlement was signed at Takahanga Marae in Kaikoura on the 21st of November 1997. The settlement included \$170 million pay retribution, an official apology from the Crown, the right to claim for cultural redress, and for first right of refusal to buy state owned assets in the tribal area (Te Rūnanga o Ngāi Tahu, 2017).

The Colonising Environment

Native American academic, Maria Yellow Horse Brave Heart, established the Takini Network which conducted quantitative and qualitative research specifically addressing the connection between historical events and the impact these have on the contemporary health and wellbeing issues of American Indians and Alaskan Indians in comparison with the United States' population. Brave Heart uses the term "historical trauma" to describe a lasting "wounding" effect psychologically and emotionally that transgresses generations and carries the weight of unresolved grief (Brave Heart, 2003, p. 7). Trauma and grief are transmitted via oral traditions such as song and storytelling, and over time they become entrenched in the collective social memory. Looking at historical trauma beyond an isolating event to take in multiple events over time provides a greater understanding of the depth of the impact of historical trauma on affected populations (Reid et al., 2017, p. 12; Brave Heart, 2003).

Reid et al., (2017) use the term, colonising environment, this describes the act and impact of colonisation on indigenous people. It addresses the impact of the settler society environment with numerous injustices on the culture of Ngāi Tahu. The colonising environment triggers a trauma response from Ngāi Tahu and to recover from historical trauma it is essential to address the "structural biases and psychosocial challenges of the settler state" (Reid et al., 2017, p. 174). Structural bias includes economic disempowerment, barriers to justice, insecurity and low self-esteem and Māori being disengaged from their whānau, hapū and iwi. In order to be part of the solution, Ngāi Tahu need to take action and grow their tribal identity as a whole and individually; a stronger awareness of their history will assist them to move forward and heal past trauma. Ngāi Tahu members have, however, become more equipped with

positive and productive strategies to cope better with the historical trauma. Reid et al. (2017) have outlined the following strategy fields as identified in their research report:

- Effort across the iwi structure from iwi governance to whānau, national, regional and local with whānau-led strategies. Those members most affected to be the drivers of their health and social initiatives.
- Social-political engagement through iwi, hapū and whānau activities to reverse political alienation.
- Sustainable economies to enhance cultural and psychological wellbeing.
- Tikanga Māori focused education as opposed to education premised on Pākehā values.
- Connecting with the land to foster a sense of belonging. This could be in the form of working the land, gathering food or researching whakapapa.
- Obtaining cultural confidence in a particular area, such as te reo, tikanga, whakapapa, kapahaka or whenua activities.
- Ngāi Tahu members feeling comfortable in their Ngāi Tahu identity.
- Acceptance of the varying degrees of Māoriness; those who have cultural fluency to those who have less.
- Gaining and sustaining cultural pride and mana that counteracts the “shame generated by colonial narrative” and reinforces all the aforementioned coping strategies listed above (2017, p. 176).

These tribal events have shaped Ngāi Tahu and have had a significant impact on their identity today as a people. Census data have located the descendants of Tahu and provided snapshots of their state of being at given times. They provided a timeline that contributed to the Royal Commission reports, the petitions to government by Māori and supported the overall picture of Māori socio-economy, health and education of Ngāi Tahu post Te Tiriti o Waitangi. Equally, the census data provided Māori findings of neglect and disempowerment, capturing a daunting reflection of what Māori suffered over many generations in the reclamation of their rights as Te Tiriti o Waitangi partners (Anderson, 1990; Evison, 1997; Kelly, 1991).

Ngāi Tahu Population

The very first statistical data gathered on the Ngāi Tahu population and location by the Crown took place in 1843. The Crown initiated this data collection in order to know who should be paid monies from land purchased by the New Zealand Company. Consequent attempts were made through the Royal Commissions (1868, 1887, 1911) and the Middle Island Native Census (1891) but it was the revised 1925 Māori Land Court order in 1929 by the Ngāi Tahu Census Committee where the 1848 kaumātua (elderly Māori) list was officially accepted.

The *Blue Book* of the kaumātua alive in 1848 that could trace their whakapapa to Ngāi Tahu is a resource vitally important to the iwi. The concept of the blue book itself was instituted through the New Zealand Governor, who annually gathered statistics into a blue book for the British Government. Blue books were produced yearly from 1840 to 1855 and contained information on the European population in New Zealand during this time. Statistics New Zealand's first attempt to count the Māori population in New Zealand took place between 1857 and 1858. The Native Secretary gathered handwritten lists of names supplied rough estimates of the Māori population at this time. Māori in the South Island were thought to only make up four percent of the total Māori population, therefore, to save money, South Island Māori data were collected on the European census between 1916 and 1951 (Statistics New Zealand, 2017). From 1951, the European and Māori censuses were collated into one census as a general New Zealand census.

In 1966, the government legislated Section 16 of the Māori Purposes Act, which officially withdrew subsections seven to ten of Section Six of the Māori Trust Boards Amendment Act of 1965. This allowed for the Ngāi Tahu Māori Trust Board to use the *Blue Book* list of kaumātua (mentioned above) to determine who their beneficiaries would be over the original roll provided by the 1925 Māori Land Court (Kelly, 1991; Ngāi Tahu Māori Trust Board, 1963; TRONT, 2017). The passing of both the Māori Affairs Amendment Act 1974 influenced more refining of the census questions. The term *race* was changed to *ethnicity*, with further refinements taking place over the coming years to enable the use of the term Māori to be accepted as a census ethnicity

descriptor (Māori Affairs Amendment Act 1974, Section 2). The term ‘race’ became associated with a hierarchy of skin colour; white races were perceived as genetically superior. This theory then transitions the social concept of race as a biological construct that bases judgement and rules around intrinsic differences. This interpretation of race inevitably places white people above black people. Indigenous researchers and writers, such as myself, need to be aware of these social and biological constructs and use them wisely so as to not perpetuate a term that is derogatory to Māori and other Indigenous cultures (Callister, 2009; Jackson, 2018; Paterson, 2010, Reid & Robson, 2006)

In 2020, there are 67,000 Ngāi Tahu members. Ngāi Tahu make up just over one percent of the total New Zealand population, and just over eight percent of the total Māori population. Ngāi Tahu is the third largest iwi in New Zealand and the largest iwi in the South Island.

The median age of Ngāi Tahu members is 25 years. This is older than the median age for the total Māori population, which is 23 years for females and 26 for males compared to the non-Māori population median age of 38 years (Statistics New Zealand, 2017). The Ngāi Tahu population is a young population, with 32.4 percent under 15 years and 50 percent under the age of 30 years, and the population is predicted to continue this growth pattern of a young population alongside the overall growth boom of the general Māori population. Māori are also living longer; six percent of Ngāi Tahu members are over the age of 65 years, which is an increase of 1017 members since the last census in 2006. Ngāi Tahu are birthing on average 1.7 babies, which is a fraction less than the overall Māori population of 1.9, and females dominate in the gender statistics currently, with the population balance being 53.8 per cent female and 46.2 per cent male (Statistics New Zealand, 2013).

Most Ngāi Tahu live in a one family household situation (82.7 per cent), with few living in one person households (6.6 per cent); 59.4 per cent of couples, parent together compared to 22.5 per cent who are single parents (Statistics New Zealand, 2016). Over half of the Ngāi Tahu population (51 per cent) do not smoke or smoke irregularly, 76.9 per cent hold formal qualifications and 72.4 per cent are working and living in urban settings. The average income for a Ngāi Tahu member is \$27,500 (Statistics New Zealand, 2016).

The forecast indicates that Ngāi Tahu, alongside all iwi Māori, will continue to grow. It is also expected that Māori infant mortality rates will continue to decline due to preventative interventions, such as immunisations and improvements in socio, cultural and economic status (Cowan, 2015). Ngāi Tahu is also seeing an increase in the numbers of young Māori who feature in the optimum age groups for sustaining greater numbers of births. Those two things, more babies surviving infancy and age demographics being conducive to increased births will sustain the growth of the Ngāi Tahu population into the future.

Understanding the population demographics of Ngāi Tahu assists in the appropriate development and delivery of maternity services. Midwives will have a greater understanding of their clientele to deliver appropriate care. Also, to address secondary health issues that may impact the wellbeing of the mother and child in the course of her pregnancy and birth. It is important to understand the wider context of economics and who else may be living at home or within a rental situation. The growth of the Ngāi Tahu population provides an argument for the development of more Ngāi Tahu appropriate resources and culturally focused options within the maternity services for Ngāi Tahu whānau.

Whakarāpopoto (Summary)

The literature reviewed in this chapter is predominantly historical in nature from New Zealand authors, such as Herries Beattie, Atholl Anderson, Te Maire Tau, Harry Evison, Māori Marsden, Ian Pool and Tipene O'Regan, with the addition of Indigenous authors, such as Patrisia Gonzales, Gregory Cajete and Katsi Cook sharing their insights and research from their indigenous communities. The offerings from these authors provided context surrounding the historical and cultural situation in which this thesis is encased. Literature from Te Rūnanga o Ngāi Tahu in preparation for their claim, *Te Kerēme*, by Tipene O'Regan, Te Maire Tau, Harry Evison, Trevor House and many others, and the Waitangi Tribunal Report (1991), was also vital in the breakdown of the large land transactions and Treaty failings.

Royal Commission of Inquiry Reports (1879, 1881, 1887, 1891, 1905, 1906) also presented sad truths directly from the mouths of Ngāi Tahu leaders. Their recorded comments to the leading commissioners summarised succinctly the sentiments of those they represented. All Ngāi Tahu authoritarians repetitively argued that official Government inquiries did not equate to rectifying the mistakes of the Crown. On the contrary, the reports from the Commissioners were either discarded due to a funding cut or the report resulted in stronger wielding legislation that did not lighten the burden placed upon Ngāi Tahu but instead secured the reins of power even further into the hands of the Crown representatives.

There is a moderate amount of literature on the historical Ngāi Tahu context to set the scene for this thesis but there is very little literature giving any specific details about Ngāi Tahu birthing traditions and practices. Childbirth and maternity practices are not often found in the indexes of books about Māori history or even within chapters on the family life of Māori. This information appears to not have been written about, or those who provided earlier historical accounts in Aotearoa, such as: traders, explorers and missionaries were not privy to the knowledge. Ngāi Tahu detail on customary birthing practices is scarce and obtaining it challenging. Small references or mentions of childbirth and practices often hold scant detail and rarely provide a full picture of conception, labour and birth, and the associated rituals and practices. Finding little information in the literature under general searches did not deter me from pursuing this

kaupapa; like my masters, it challenged me. I was driven by the fundamental importance that this knowledge needs to be found, relearned and reintegrated into current maternity services. This is supported by the reading of *He Reo Wāhine Māori Voices from Nineteenth Century* by Paterson and Wanhalla (2017), who acknowledge how colonial archives written predominantly by men smother the views of all women, but more grossly of wāhine Māori. However, these actions, archival collections and the historical gathering of data with little interest in wāhine Māori did not silence wāhine Māori. Paterson and Wanhalla (2017) believe that by searching a little deeper and paying attention to seeking the opinions of wāhine Māori, more can be found that brings their stories, viewpoints and presence to the fore.

The key learnings in this literature review were the following:

Wāhine Māori have been disempowered through colonisation, assimilation and the hospitalisation of birth. The role of the woman as the universal mother, the generator and nurturer of life, was eroded with male storytellers providing their perspective that eventually became the accepted reality. Therefore, resurrecting birthing rituals and practices according to authors Bruyere (2012) and Gonzales (2012) will reinstate the role of the creator and that of the woman; and more female storytellers sharing our creation narratives will also contribute to placing the female energy back into creation mythology.

Learning about the mythology of a people is a telling device through which to understand their identity and cultural values. Mythological narratives are repositories of timeless moral encounters that are revealing for listeners, both historically and now. Embedded symbols and wording provide mythological depth, saying less but meaning a lot. Māori symbolism within mythology illustrates another reality, according to Marsden and Henare (1992), and one that requires all senses to interpret the many repository realms of knowledge.

Creation stories assist the process of keeping Ngāi Tahu stories in our living memories. As a mnemonic tool, pūrākau or stories often describe a life cycle from the germination of a seed through to death in order to commence the life cycle again. In the Mexican Indian culture, storytelling is a form of medicine because the stories carry traditional knowledge. By sharing the stories, you are strengthening a person's identity and wellbeing. Tribal creation stories are an important tool in the development of a child's

understanding of who they are by reinforcing the morals and values of their tribal affiliations. Highlighting Ngāi Tahu creation stories and the key messages within strengthens people's ability to remember their ancestral connections and their relation to the Universe. Colonisation has played a strong part in suppressing our creation narratives and conditions our thinking of our own tribal values and norms to the morals and ethics of the majority culture (Kirby, 2007).

As a tribe, Ngāi Tahu's evolution has been a story of grit and determination but not without hardship and loss. The arrival of Ngāi Tahu into the South Island commenced growth in their trading economy. This led to intermarriages and international trading relationships. Therefore, Ngāi Tahu looked favourably at Te Tiriti o Waitangi as an opportunity to foster bicultural partnerships and further economic growth. Ngāi Tahu experienced being in the majority initially when the settlers arrived to quickly becoming outnumbered by European settlers in the 1830s when the population of Ngāi Tahu was approximately 2500; with an influx of over 500,000 settlers to New Zealand between 1820 and 1890 the scene was set for dramatic change. That included movement by Ngāi Tahu away from their hapū kaika (villages) and away from their extended kaika whānau as they transitioned and assimilated to European settlements and their lifestyles (O'Regan, 1991; Tau, 1997, 2013; Waitangi Tribunal, 1991).

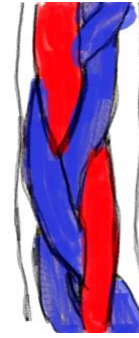
Early settler governments did not enforce accountability to Te Tiriti o Waitangi and promises were continually broken. Reid et al. (2017) states that material poverty and disease are core components of Māori historical trauma from a colonising environment. Ngāi Tahu at this time lost their access to mahinga kai (food sources) and had minimal political autonomy. The only thing left for this iwi to do was fight back and that they did, over generations and multiple petitions and visits to Crown representatives. Ngāi Tahu figuratively carved a pathway to Parliament with their repetitive land claims and insistent demands for righting wrongs against them. After a lengthy period of time, the Crown realised there were truths to the pleas of Ngāi Tahu.

The Ngāi Tahu claim, Te Kerēme, strategically bundled all nine claims into one package and delivered yet another message from the iwi to gain retribution for the broken promises and the denial of rights under the Tiriti o Waitangi over the reserves and assets promised in the significant land purchases including: Kemp, Ōtākou, Murihiku, Arahura, and many others. The Waitangi Tribunal findings and report in

1991 and the Settlement Deed in 1997, with a later apology from the Crown, was a bitter-sweet victory for Ngāi Tahu witnessed by the descendants of those who started the battle to right the wrongs of the past.

Ngāi Tahu customary birthing rituals and practices are another vitally important factor in the restoration of Ngāi Tahu wellbeing. Rediscovering knowledge pertaining to conception, labour and birth is another decolonising mechanism that empowers not only Ngāi Tahu as a collective but also Ngāi Tahu wāhine as equal partners in the revitalisation of cultural practices. Hospitalisation of births denies cultural input and not only sanitises the birthing process but the culture of the people. To aid the healing of historical trauma, inclusive of forcing birth away from the home, is to remove the layers that have oppressed wāhine Māori for too many years eventuating in wāhine Māori dominating negative health and education statistics and accepting less than they deserve.

The thesis will explore more deeply the power of birth, the role of mythology as a cultural methodological tool and the historical context that led to the decline in customary birthing practices and rituals. This thesis will also investigate the current maternity situation for Ngāi Tahu and what recommendations and challenges can be presented in order to greet the future generations of Ngāi Tahu with a collaboration of customary birthing knowledge and modern technology. How this thesis evolves from this point will be described in the following methodology chapter that highlights a kaupapa Māori approach and methods used to access the knowledge repositories.



3

Whakatō Tamariki / Methodology

Io io whenua, Tipu kerekere, Tipua anana...

Ko te Tīmatatanga (Introduction)

The methodology provides a framework for both the researcher and the reader to understand how a study is conducted, examined and applied. Careful planning of the methodology was essential when configuring this research project. This ensured that the research process honoured the kaupapa rangahau (research topic), the research participants and the hapū they represented in all phases of this study. Methodology offers the rationale behind a set of instructions that work to complete a project while preserving respect for the participants and their data (Smagorinsky, 1994). This research includes the kōrero (oral kōrero) and pūrākau (stories) of tūpuna Māori (Māori ancestors) who are no longer here in person but who have communicated their knowledge to historians or deposited their wisdom in waiata (songs), karakia (incantations) and manuscripts to ensure the knowledge survives.

This project is a qualitative study that used kaupapa Māori theory to search for information on the reclamation of traditional Ngāi Tahu birthing practices within today's maternity services and midwifery training. Kaupapa Māori provides a holistic approach that embraces the flow of time between the past, present and future. These

well-known Māori whakataukī (proverbs) are examples of how Māori look to their past to attain knowledge to guide them into the next phase of life. For instance, *ka mua, ka muri*, infers to look back in order to go forward. This whakataukī *kia whakatōmuri te haere whakamua* illustrates a person metaphorically walking backward into the future with their eyes fixed on their past. Keeping our past close to us through archival recordings and activation of knowledge through tikanga and kawa will keep customary practices at the forefront of our thinking, and in our daily lives. Traditional or customary knowledge aligns to whakapapa and the whenua. A whakataukī that captures this sentiment is, *kia heke iho rā i ngā tūpuna, kātahi kā tika*, which translates as ‘if it is passed down by the ancestors it will be correct’. These whakataukī reinforce the use of a kaupapa Māori methodology and support this doctoral research.

In section one of this chapter, the research questions are provided with an interpretation of kaupapa Māori theory and how it is aligned to the preferred methodological framework. Educationalist and academic Graham Smith (1997) collated six principles of kaupapa Māori research and fellow scholars provided more discourse and an additional principle (Jenkins, 2001; Pihama, 2001; Smith, 2000).

The seven principles that have guided this research project are listed below with more detail provided in section 3.1:

- Tino Rangatiratanga – The Principle of Self Determination
- Taonga Tuku Iho – The Principle of Cultural Aspiration
- Ako Māori – The Principle of Preferred Pedagogy
- Kia Pike Ake i Ngā Raruraru o te Kainga –
The Principle of Socio-Economic Mediation
- Kaupapa – The Principle of Collective Philosophy
- Tiriti o Waitangi – The Principle of the Treaty of Waitangi
- Ata – The Principal of Growing Respectful Relationships

Section two addresses the choice of methods used to gather the research data and the research design, such as data from: audio and literature archives, pūrākau (historical stories/mythology), semi-structured qualitative interviews, focus groups facilitated

through two wānanga (focus group workshops) held at Ngāi Tahu marae, fieldnotes taken from individual interviews and wānanga, internet and visual repositories of knowledge, including Māori symbolism in an array of Māori art forms.

Section three concludes the methodology chapter with a description of how the data was analysed and methods used in this process. With the utilisation of a reflexive thematic analysis viewed through a kaupapa Māori lens, themes were drawn from the interviews, visual sources and literature to provide discussion points throughout the thesis.

3.1 Section One: Kaupapa Māori Theory and Methodology

Under a kaupapa Māori philosophy, as adhered to in this study, the researcher not only has a relationship with the research participant but with their whānau, their hapū, and their iwi. In the case of the two wānanga held at Rapaki and Arahura, my relationship as researcher extended to the Marae, the Marae administrator, and the Rūnanga to allow me to research at the Marae. Following a tikanga process that alleviated the stress and unease that can eventuate if protocols have not been respected. Therefore, time was taken to arrange interviews not only with the individual research participants but with their whānau caregiver or Rūnanga to minimise barriers to effective qualitative interviewing. Davis (1999) described the presence of the researcher and the researcher's control over the research process as interwoven with their involvement with the community, place, and topic of the research. I also recognised that, because of these interconnections, I was influenced strongly by the views of my iwi, particularly by elders whom I respect and regard as cultural mentors. Limitations may be seen in terms of the valuing of these people and their narratives, leading to a lessened ability to critique their knowledge.

As a Ngāi Tahu wāhine and hākui, I feel intimately involved and obligated to this research; this is my hāpori (community) and my tūrangawaewae (place of standing). These familial connections aided with accessing participants and information sources but not without the burden of delivering a product that meets both the academy's doctoral requirements and those of my hapū and iwi. The qualitative research approach and philosophy I have chosen for this mahi rangahau (research work) is under the korowai o te kaupapa Māori whakāro: the cloak of Māori theory, understanding and methodology. I examine these foci in the next section in order to further situate the methods and research approach.

At the very heart of kaupapa Māori, is mātauranga Māori (knowledge of the Māori world) and whakapapa (genealogy) (Edwards, 2009; Marsden, 2003). Mātauranga Māori is enlightened by whakapapa and allows Māori to make more sense of tō rātou Ao (their world) and their relationship within it (Cram and Mertens, 2016). Whakapapa connects people, all living things, and the environment; understanding how whakapapa

operates on many levels and helping researchers to work with whānau in research, as well as addressing how to be a researcher (Jahnke & Gillies, 2012; Stevenson, 2018). Leonie Pihama (2001) adds that mātauranga Māori describes being Māori and the way Māori do things. Kaupapa Māori is the layers of knowledge and philosophy that reinforce Māori identity. Cram (1993) stated that Māori knowledge upholds the integrity of the Māori community, which she argues differs from the Pākehā view of knowledge as cumulative, drawing knowledge elements together to form universal laws.

Linda Smith (1999) situates kaupapa Māori in the echelon of Māori striving for self-determination. According to Tuakana Nepe, kaupapa Māori is an ancient term that, in recent history, has become popular or perhaps better understood with the growth of Māori research and researchers. Mane (2009) agrees that Māori research has highlighted kaupapa Māori as a term and a practice. However, due to a decrease in Māori speakers and those competent in tikanga, kaupapa Māori is under threat of being forgotten or underutilised. Mane argues that tikanga (customs) provide a “cultural foundation that is distinctly Māori and driven from Māori worldviews and values” (p. 2). The lack of fluent Māori speakers for Ngāi Tahu has created a grave concern for the iwi governance within Te Rūnanga o Ngāi Tahu. They have attributed to the decline in ceremonial customs, to assimilation and land alienation that led to the loss of te reo Māori (Māori language) me tikanga (tradition) fluency (Waitangi Tribunal, 1991; Reid et al., 2017).

Tikanga is articulated through te reo Māori, and the depth of the practice is captured in the words of karakia (incantations). To give voice to the karakia is to give breath to the tikanga practice. The use of any language other than Māori in customary Ngāi Tahu practices can be perceived as diluting the mana of the practice and a threat to the validity. Ngai Tahu's Language Strategy, Kotahi Mano Kaika 5-year plan 2017-2021, administered by Ngāi Tahu's Kotahi Mano Kaika team is a proactive step towards the reclamation of the Ngāi Tahu voice and cultural practices (O'Regan, 2001, 2009; KMK, 2019).

Mereana Taki (1996) expressed kaupapa Māori in the partitioning of these kupu (words) *ka u papa*. Taki described *ka u* as holding firm and laying down the foundations of our existence and, for Māori, this can be seen as holding and developing a stronghold

on Papatūānuku. *Kau* can also relate to capturing an insight into something for the first time, being privy to a disclosure. *Papa* can also be regarded as the short name for Papatūānuku, the layers of the earth, a medium or a loud noise (Ryan, 1999). It can also emphasise through repetition of something being touched (pā) physically or spiritually by something else. *Papa* is an intensifier of the root word “touch”. Taki's description of kaupapa Māori affirms the approach I feel most strongly aligned with all my research projects, regardless if they are kaupapa Māori driven or not. Māori researchers naturally bring themselves to the research, and this is because we epitomize kaupapa Māori (Taki, 1996). I perceive what Taki describes in the breakdown of the word kaupapa as a ground-up approach that captures the many layers of a research project yet upholds the values associated with Papatūānuku (Earth Mother). This reminds us as researchers to honour the kaupapa and to nurture the research participants (Taki, 1996). Kaupapa Māori in this instance, is to conserve the integrity of the research goal(s) while staying true to self as a Ngāi Tahu wāhine researcher.

The inclusion of Māori into the research process as researchers was becoming more strongly recognised throughout academia in the 1980s. The Māori education movement also arose in this period, which had a significant bearing on how Māori and education would evolve in the years to follow. Māori education leaders and writers instigated the establishment and support for Māori immersive education, such as Kōhanga Reo (preschool language nests), Kura Kaupapa (primary immersion Māori schools) and Whare Kura (tertiary immersion education). These kura (immersion schools) are repositories of learning formatted by te ao Māori and immersed in te reo Māori (Māori language), which provided a momentous wave of passion for the revitalisation of Māori culture and iwi (tribal) development. This, in turn, has facilitated some awareness of recognising Māori values and ways of doing things within broader education and learning spheres. Graham Smith (1987, 1990, 1997) argued that the campaign for Māori knowledge and Māori-immersed education has further defined the concept of kaupapa Māori for Māori people and also for the broader New Zealand community.

Glover (2002) claimed that kaupapa Māori research was also influenced by a global Indigenous movement to autonomise their rights over land and language. Powick (2003) aligned a surge in kaupapa Māori researchers and methodology to a commitment to Te Tiriti o Waitangi, encouraging better and equal collaboration between Māori and

non-Māori. Rangimarie Mahuika (2008) described kaupapa Māori as a “theory of liberation” for Māori (p. 2). Mahuika argued that kaupapa Māori theory had enabled Māori researchers and Māori research to:

...challenge mainstream attitudes and understanding towards issues of relevance for Māori and make space for the articulation of Māori ways of knowing and being. Its greatest potential may lie in its ability to challenge Māori to develop a greater awareness of who we are, what it is we want, and how we want to go about achieving that (2008, p. 11).

Māori research is a valuable tool for Māori and New Zealand. Māori research is empowering; it is knowledge and is progressive (Smith, 1997, 2003; Smith, 1999). Irwin (1994) contends that kaupapa Māori research sits within its paradigm by setting out the depth of study, what needs to be studied, and the questions to be included. Irwin (1994) says kaupapa Māori has theories to derive an internal value system and a knowledge foundation. Cram et al. (2018) added that kaupapa Māori does not instruct the researcher on the particular methodology or method to use for their research but promotes researchers to engage with kaupapa Māori and find the most appropriate research methods for the research.

In my research, I have found that interviews and kōrero (open, flexible, wide-ranging discussions) and hui have been the best fieldwork data acquisition and learning methods. They are also known and familiar to Ngāi Tahu members involved in this research. I also employed a number of kaupapa Māori principles, including whakawhānaungatanga (getting to know one another) and establishing whakapapa (genealogical connections) to facilitate the research, these are discussed in section two.

Kaupapa Māori research, according to Henry and Pene (2001) and Irwin (1994), is made culturally safe with the enlisting of kaumātua (Māori elders). Kaumātua mentor the researcher through the research process to ensure they remain true to themselves as researchers, and to the kaupapa being researched. Bishop (1996) added that kaupapa Māori research must be founded on self-determination, legitimacy, authority, and empowerment for Māori (p. 236). Henry and Pene (2001) discuss kaupapa Māori as a “manifestation of cosmology.” The challenge for Māori researchers utilising kaupapa Māori research methodologies is the perpetual need to gain and hold space for the inclusion and nurturing of traditions (p. 238).

Collectively, those who have written about and addressed kaupapa Māori and kaupapa Māori research are forging a style of research that has been motivated by a need to reposition Māori people within the research paradigm as drivers of research, as primary investigators, and preferably from the community that the research is located (Irwin, 1994; Mahuika, 2008). The research and recommendations can be employed across community and government services. Directed at meeting the needs of te iwi Māori by enhancing service delivery (Bryant et al., 2016). Rangimarie Mahuika (2008) stressed that kaupapa Māori allows for lived experiences and truths to be told in the voice of those expressing them. Acknowledging the unique cultural lens that Māori identify with, and which identifies us, are essential attributes (Mahuika, 2008). Again, these features are central to my research.

From the Tewa clan in Mexico Professor Gregory Cajete (1999), supports cultural expression in all domains. He explains that we can investigate, explore and understand our cultural knowledge by communicating with those within the culture and beyond. Transfer of cultural knowledge appears to have declined in tribal importance and is seen more in the realm of the ceremony, not in everyday living. The expression of cultural knowledge will protect cultural values and reduce the risk of Indigenous people being bystanders to their own culture as others articulate or scribe their tribal customs and rituals. Cajete reiterated that holding onto ancestral knowledge and teaching it liberates Indigenous people to maintain or retract tribal autonomy.

In light of Mahuika (2008) and Cajete's (1999) views, the utilisation of kaupapa Māori within research can be seen as a tool of iwi autonomy. However, some Māori scorn the alignment of kaupapa Māori with mainstream academic institutes, saying that the concept of kaupapa Māori becomes theorised or open to criticism by academics. The concern is the fear of colonial or majority groups judging whether traditional Māori knowledge is essential or remains beneficial in the current climate. In the face of poor social, health, education, and economic statistics, being critiqued on the validity and context of kaupapa Māori from members of the academy is a valid reason that some Māori want to protect it from this realm (Eketone, 2008; Pihama, 2008). Eketone (2008) suggested that kaupapa Māori could be observed as a "theoretical construct" within the academy, thus removing it as a living entity from the Māori community. Other academics have warned that kaupapa Māori is associated with the establishment of

Māori elitism, and this in itself can be an oppressive tool over others in the iwi (Rata, 2006).

There are other views of kaupapa Māori. According to one of its original vital proponents, Graham Smith (1992), it is “the philosophy and practice of being Māori” (p. 1). Kaupapa Māori is an ancient term, according to Tuakana Nepe, that has become more popular in recent history as a research tool with the growth of Māori research and researchers. Therefore, regardless of whether the academy takes up the term of kaupapa Māori and shines a scholastic light upon it as a theory or concept. Ultimately, the most crucial thing presently is keeping Māori traditional knowledge alive, accessible and active. Indeed, this is an underlying goal of this thesis research journey; to re-learn, renew, and revive Ngāi Tahu birthing traditions and knowledge. Similar to the threat upon the survival of te reo Māori (Māori language), the task of aiding the retention of te reo Māori, of speaking it, teaching it and learning te reo Māori is the responsibility of many. Non-Māori midwives have asked me if they should be using traditional Māori birthing practices with their whānau Māori (Māori families) or whether this momo mātauranga (particular knowledge) should be left to Māori midwives only to deliver. I reply that our lores of tikanga ooze commonsense and practicality. We currently do not have enough Māori midwives to attend all Māori births, and we do not have enough midwives advocating for, and providing customary birthing practices, within the birthing plans of whānau. Therefore, like te reo Māori, the more advocates of this knowledge, the higher chance customary Māori birthing practices will be revived in Te Waipounamu.

Kaupapa Māori theory and methodology lie within our creation philosophies. The creation narratives or pūrākau (stories) are used to aid the retention of traditional knowledge as they frequently communicate tikanga (customs) and whakaaro Māori (Māori philosophy) (Nepe, 1991; Pihama, 2008). In customary, especially pre-contact times, Māori have always been methodical in their approach to life. In order to survive, our tūpuna (ancestors) were, in effect, practical researchers. They worked on a whakāro (concept), practiced that whakāro, evaluated it, and adjusted the methodology. Eventually, Māori produced a result that was incorporated into improving their way of life. Examples of this are in the realms of rongoā Māori (Māori medicine), mahinga kai (traditional Māori food preparation and cultivation sites) and how Māori adapted their

knowledge stemming from their homelands in Hawaii to the natural resources available to them within this new terrain (Beattie, 1994; Best, 1934, 2005).

Today, the same principles of practical, functional or “applied” outcomes derived from kaupapa Māori research are relevant and essential. Kaupapa Māori research has taken many forms but has in common a responsiveness to the people. The following is a useful example of how kaupapa Māori research can effectively respond to the priorities and needs of Ngāi Tahu. *Whaikaha Mana Māori: Living unique and enriched lives* (2014), a report to the Health Research Council and the Ministry of Health, investigated the accessibility and barriers to health and disability services faced by whaikaha Māori (Māori living with disability) and their whānau (family) in the Murihiku area (Southland). Bishop (1996) argues that kaupapa Māori investigates the understanding of something within a Māori worldview. He highlights the growing literature about kaupapa Māori theory and practices that encourage the development of Māori frameworks. These frameworks can be used by Māori researchers to bring about positive change and development for Māori (Jenkins and Pihama 2001).

Two emerging Māori researchers led the research, alongside a whaikaha Māori research advisory group. A case study design was implemented with data gathered from whaikaha Māori and their whānau, and organisations providing health and disability services in Murihiku. Key findings from this study include the need for a professional advocacy service to assist whaikaha Māori (Māori living with a disability), more effort in building rapport with whaikaha Māori, service flexibility to accommodate the needs of their clients and a better collection of ethnicity data to know and value their clientele, in order to better the service delivery. Using a kaupapa Māori methodology for this piece of research allowed Whaikaha Māori to be viewed holistically, for instance, not disabled *and* Māori or Māori *with a* disability but their taha Māori and their disability were seen as one. This was a frequent point of contention for the participants who felt that their disability limited their ability to carry significant roles with their Māori community.

Public health physician at Waikato District Health Board, Nina Scott, addressed the importance of kaupapa Māori methodology, advising not only the study but also informing the development of solutions. Scott reiterated that kaupapa Māori “speaks to the need for Māori leadership, expertise and involvement in solution development,

implementation, and monitoring” (2014, p. 10). Moreover, these are underlying principles for my doctoral research. Kaupapa Māori approaches alignment with the transformative elements of Paulo Freire’s (1970) philosophy. Brazilian educator and philosopher Paulo Freire’s (1970) *Pedagogy of the Oppressed* described dialectical interchange as a dialogue that takes place between people and situations with an exchange of ideas, thoughts, and concerns that can transform a situation. He argued that the key is for people to discover the cause of the oppression or the urgent problem that is smothering the growth of something or someone. The solution to oppression, according to Freire, is to perceive oppression as a limiting situation from which they can transform, and not one from which there is no exit or escaping (1970, p. 34). Kaupapa Māori theory and methodology relates well to Freire’s thoughts on liberation as his ideas allow us to look at his approach to problems or, specifically, at oppression in education and social situations to support the importance and practical application of kaupapa Māori methodology in research, and of Māori knowledge in the growth of te iwi Māori today.

Now that I have discussed the broader contextual issues and interpretations of kaupapa Māori research, I turn to discuss specific methodological elements and examine them in relation to Ngāi Tahu, my case study iwi community, and in relation to my specific research.

Identifying the critical principles of kaupapa Māori research

Graham Smith (1990) identified critical principles of kaupapa Māori that inform and assist the undertaking of research. Other senior researchers, such as Linda Smith, Leonie Pihama and Taina Pohatu, have also contributed to the development and application of these principles. The kaupapa Māori methodological tools identified by the Māori researchers above have been selected to frame this doctoral thesis. A personal interpretation of these principles and those expressed by the researchers has shaped this research approach.

Tino Rangatiratanga – The Principle of Self Determination

Within a kaupapa Māori research paradigm, tino rangatiratanga is about seeking the research data under a kaupapa Māori or tikanga Māori approach. This can be interpreted as growing Māori researcher capacity and using our knowledge bases to analyse the data. The principle of tino rangatiratanga is the reclamation of autonomy and control over one's life as well as those of the collective. It also encompasses the notion of feeling supported individually, within the whānau (family), as well as the wider hāpori (community). The purpose of the word “tino” is to intensify the word that follows it. It translates in English as “very” or “absolute”. Rangatiratanga derives from “rangatira”, meaning chiefly leader. Rangatira combined with “tanga” is rangatiratanga, which means chieftainship or sovereignty (Ryan, 1999; Williams, 1985).

Helen Wihongi (2010) described tino rangatiratanga as the mana (respect) and tapu (sacred) belonging to a rangatira (chief). Mason Durie (1998) referred to rangatiratanga as the “right to self-determination and rights to development” (Smith and Reid, 2000, p. 20). Expressing tino rangatiratanga indicates a need to be self-determining and to develop the skills to do so. Therefore, this principle in relation to this research refers to the reclamation of autonomy and control over our own lives and feeling supported within ourselves, our whānau, and hapori (community). Tino rangatiratanga was, as Wihongi (2010) stated, the “catch cry for Māori resistance” in the late 1960s (p. 3). Young Māori who deplored the government's lack of accountability to the Treaty of Waitangi/Te Tiriti o Waitangi would campaign for tino rangatiratanga. Wihongi (2010) wrote that a collective of well-educated Māori believed the Treaty of Waitangi was a deception and protested about the unfair inequalities between Māori and Pākehā in many Crown institutes.

The term tino rangatiratanga was originally incorporated into the 1835 Declaration of Independence signed by 34 northern chiefs, who called upon King William IV of Britain to protect them. By 1839, another 25 chiefs had signed the declaration. This collection of chiefs came under the banner of the Confederation of the United Tribes. The beginning of the declaration reads as follows:

Ko mātou, ko nga Tino Rangatira o nga iwi o Nu Tireni i raro mai o Hauraki kua oti nei te huihui i Waitangi i Tokerau i tera 28 o Oketopa 1835, ka whakaputa i te (Rangatiratanga) o to matou wenua a ka meatia ka wakaputaia e matou he Wenua Rangatira, kia huaina, Ko te Wakaminenga o nga Hapu o Nu Tireni (Ministry of Culture and Heritage, 2017).

We, the hereditary chiefs and heads of the tribes of the Northern parts of New Zealand, being assembled at Waitangi, in the Bay of Islands, on this 28th day of October, 1835, declare the Independence of our country, which is hereby constituted and declared to be an Independent State, under the designation of The United Tribes of New Zealand (Archives New Zealand, 2017).

Tino Rangatiratanga is also the key element of Article Two of the founding document of New Zealand, Te Tiriti o Waitangi/The Treaty of Waitangi 1840:

Ko te Kuini o Ingarani ka wakarite ka wakaae ki nga Rangatira ki nga hapu – ki nga tangata katoa o Nu Tirani te tino rangatiratanga o ratou wenua o ratou kainga me o ratou taonga katoa. Otira ko nga Rangatira o te wakaminenga me nga Rangatira katoa atu ka tuku ki te Kuini te hokonga o era wahi wenua e pai ai te tangata nona te wenua – ki te ritenga o te utu e wakaritea ai e ratou ko te kai hoko e meatia nei e te Kuini hei kai hoko mona (Archives New Zealand/Te Rua Maharao te Kawanatanga, 2017).

The Queen of England agrees to protect the Chiefs, the subtribes, and all the people of New Zealand in the unqualified exercise of their chieftainship over their lands, villages and all their treasures. However, on the other hand, the Chiefs of the Confederation and all the chiefs will sell land to the Queen at a price agreed to by the person owning it and by the person buying it (the latter being) appointed by the Queen as her purchase agent (Kawharu, 1988).

Sir Hugh Kawharu (1988) translated the term tino rangatiratanga or chieftainship as meaning that the Queen will give complete control to the chiefs; he translated “tino” as “quintessential”. The protection of rangatiratanga within the Treaty, as agreed upon by the Crown and the chiefs on behalf of their hapū collectives, has been a central focus of Māori communities within health, education, and environmental matters since the signing of the Treaty. Its proper and full recognition is an ongoing challenge for Māori. The countless Treaty claims to address the lack of accountability to Article Two have been exhausting and necessary for all iwi and hapū and whānau with Treaty grievances. Ngāi Tahu's extensive battle with the Crown and their bid for retribution under the claim titled Te Kerēme (the claim) sits vividly in the minds and hearts of many Ngāi Tahu. Te Kerēme epitomises the true nature of tino rangatiratanga; that was lost through land

acquisitions, and for which the settlement hinges upon in terms of its restoration (more on Te Kerēme under the heading Te Tiriti o Waitangi in this chapter) (Evison, 1988; Fisher, 2017; Price, 2001; Waitangi Tribunal Report, 1991).

The national Māori flag is often raised alongside Māori protest. Through association, this flag has become known as the “tino rangatiratanga flag”. Initially, this icon of protest was a collaborative creation by the group known as Te Kawariki (comprising Hiraina Marsden, Jan Smith and Linda Munn) in 1989. The black at the top of the flag represents Te Korekore (for the potential of something or some being). The red at the bottom of the flag is the journey from potential to the realm of being. The white within the koru pattern reflects the world of light, Te Ao Marama, the birth of a being or thing. The koru represents new life unfolding, the cycle of life, and death. The Māori flag carries a philosophical message of creation that is apt for this research project. It also extends the concept of tino rangatiratanga to embrace a chieftainship over whakapapa (lineage), our own creation stories, and mātauranga Māori (Māori knowledge). The flag provides a visual cue that acts as a constant reminder to protect all things associated with Māori to ensure the survival of the culture (Morris, 2010; Simpkin, 1994).

In 2009, the Minister of Māori Affairs, Pita Sharples, advocated for the flag to become the national Māori flag. Through a nationwide series of hui led by the Māori Party, it was decided this flag would be supported as the national Māori flag. It was also suggested at the time for this flag to be flown alongside the New Zealand flag on official occasions, such as Waitangi Celebrations. The concept of acceptance was to promote the relationship between the Treaty partners, Māori and the Crown. Sharples (2009) felt, however, that it was more about acknowledging the tāngata whenua (Indigenous people) status of Māori.

From a Ngāi Tahu perspective, tino rangatiratanga is an opportunity to highlight cultural knowledge and tikanga that we have grown from, but which we have not always maintained. The impact of being known as the iwi that is “more corporate than cultural” has been detrimental. This sentiment has been alleged over the years through colleagues, friends, and media; an in-house and derogatory stereotyping that hit the core of many Ngāi Tahu members. Being typecast has most likely had an impact on the wairua (spirituality) and confidence of the iwi post-Treaty settlement combined with the historical trauma from the impact of colonisation. Ngāi Tahu members are now

utilising the opportunities provided by Te Rūnanga o Ngāi Tahu (TRONT) and their Rūnanga to explore, grow and represent their whakapapa with more fervor and curiosity than in previous years.

Taonga Tuku Iho – The Principle of Cultural Aspiration

Taonga tuku iho refers to an ancestral treasure (taonga) being passed down through the generations (Tapsell, 1997, 1998, 2011). This term can be metaphorical, spiritual, or a specific object or body of knowledge. Taonga tuku iho refers to ancestral treasures (taonga) that have come from the past (tuku iho) and are presented to us. These taonga are knowledge repositories that physically and spiritually validate who we are and how we came to be. Taonga tuku iho repositories can be: korowai or kahu raukura (cloaks), whāriki (flax mats), wakahuia (treasure boxes), pounamu (greenstone), taiaha (weapons), tekoteko (carved figureheads), whenua (land), waiata (song), wharenui (ancestral houses), te reo Māori me ngā tikanga (Māori language and customs). Many tangible and non-tangible things can be considered as taonga left from our tūpuna for us to nurture and ensure it is available for those mokopuna yet to arrive. Within this principle, taonga tuku iho is a validation and encouragement of being Māori and the way we perceive and express being in our world. Te reo Māori, tikanga, and kawa are mechanisms of expression that guide us to be able to live spiritually and physically well (Malcolm-Buchanan et al., 2012).

Research that also honours Māori values will capture data beyond the narratives, including the mauri (life principle) of the kōrero (talk). Academic and author Paul Tapsell has written numerous publications about taonga (treasures) within our national museums, and in our marae, in relation to Māori tribal identity. Tapsell (2010) reminds us of the importance of our marae as taonga and as repositories of tribal knowledge. He wrote of the marae being Treaty agents, or as a “bonafide representative Treaty partner” that have become overlooked, not only by the Crown but by a new generation of Māori described by Tapsell as “boardroom Māori leaders” who are obtaining, with little resistance, the control of legal estates on behalf of their iwi. Tapsell stressed the significant concern is with urban-born Māori and their potential ignorance to perceive and understand the marae as an institution. It is a taonga across many domains and represents the values of their elders as store houses of tribal knowledge and whakapapa (2010, p 19).

Taonga are symbolically encoded works of art. They are mnemonic embodiments of life-lessons that continue to be carefully practiced, recited, and performed in marae contexts, ensuring the successful passage of knowledge across the generations (Tapsell, 2010, p. 24). Taonga *tuku iho* are messages about knowledge transmission and survival. Therein lies the problem and the answer: with the movement of Māori away from the marae and the knowledge these repositories hold, concern escalates over the survival of *mātauranga Māori*. Tapsell stressed that, due to our land deficit through scandalous land deals and broken Treaty promises, ancient knowledge has been passed down to a younger generation. They are given the role to manage the land and resources. Some with this responsibility are not able to grasp the significance of taonga (Tapsell, 2010). The concern is, if Māori stop being *kaitiaki* of tribal knowledge, we will witness culture through the mainstream institutes in words and stories that are not our own. We “otherise” ourselves and become isolated from who we are and as the generations are created, the knowledge gets further away from the people it is about (Tapsell, 2010).

Taonga *tuku iho* are *tohu* and windows of a Māori past but also validate things important to Māori going forward. The methodological approach to studying Ngāi Tahu customary birthing practices for this doctoral study is an affirmation of staying true to kaupapa Māori theory and practice and firmly planting ourselves in the research as researchers.

This doctoral study provides an opportunity to look at specific differences in language and terminology to describe conception, *hapūtanga* (pregnancy), and *whānau mai o ngā pēpi* (birth). The study seeks to elucidate nuances among Ngāi Tahu, Ngāti Māmoe, Waitaha, and *iwi* affiliated to the Ngāi Tahu *whakapapa*, such as: Ngāti Ira, Ngāti Wairaki, Ngāti Kahungunu and Ngāti Porou. Their worldview and lifestyles were dictated by their *whakapapa* and environmental contexts. Finding taonga *tuku iho* and learning from these resources has been both immensely enjoyable and challenging. Sitting with archaeologist Brian Allingham and discussing in detail the *tauihu whakairo* (carved prow of a war canoe) at Toitū Museum in Dunedin provided an insight into our grey areas on what the creators of these taonga (treasures/art forms) were trying to convey. Our conversations kept returning to the many references to creation narratives, not only in this piece but also in many of the design work on many of the artifacts that

Allingham had uncovered throughout his long-spanning archaeological career (Allingham, Personal Communication, March 2016).

Reading over manuscripts and other literature sources has been a journey of discovery. Many sources have fed indirectly into my research, and most have fed directly to me as an emerging researcher and clarified the context in which my tūpuna were living. Knowledge repositories, such as taonga tuku iho, have mostly been accessible to my research but the challenge lay in my ability to interpret fully the teaching that they provided.

Ako Māori – The Principle of Culturally Preferred Pedagogy

This principle concentrates on Māori knowledge acquisition and transferal. Ako literally means to learn or teach, and it provides an opportunity to explore different mediums of knowledge that provide other avenues of information (Ryan, 1999). The kaupapa for this doctoral research is not easily locatable in the literature; therefore, the vista of Māori repositories had to be explored in order to refine the search for birthing traditions. The repositories were: waiata (songs), karakia (incantations), taonga pūoro (traditional instruments), rongoā (Māori treatments), te taiao (environment), whakapapa (family lineage) and pūrākau (stories). These vessels of information contained an ancient knowledge that allowed the author to glimpse into an era of time that had escaped the pen.

Ako embraces the tuakana (senior) – teina (junior) pedagogy, which is an effective strategy often used in the education sector to enhance education engagement for Māori students (Winitana, 2012). Tuakana-teina is a customary concept that highlights the relationship between an elder and a sibling of the same sex (Mead, 2003). Henare Williams (1985) defines tuakana as the older brother of a male or an older sister of a female. A cousin of the same sex can also be a tuakana if they are in the more senior ranks of the family. Williams then defines teina to be the opposite, a younger brother of a male or younger sister of a female and a cousin of the same sex within the more junior ranks of the family. Establishing lines between tuakana and teina provided a simple social ordering process that determined the standing of someone through their whakapapa (Mead, 2003).

The tuakana-teina notion sanctions a responsibility and reciprocal process, which is often led by the tuakana, who carried the detailed knowledge of the whānau, hapū, and iwi. They were leaders, pragmatic and diplomatic in representational situations. The teina were still young in their knowledge with less experience, guided by the actions and wisdom of their tuakana (Winitana, 2012). It is a practice of having learning interactions that foster understanding and respect for the knowledge itself and the teaching of this knowledge. Therefore, the quality of tuakana-teina is that it honours knowledge sharing between people and uplifts the mana of both the teacher/senior and student/junior (MOE, 2008; Mead, 2003; Rawlings & Wilson, 2013).

This research project typifies the tuakana/teina model because it seeks knowledge from tūpuna (ancestors) as tuakana in order to assist teina (young mothers and whānau). In the qualitative interviews, the participants are kaumātua sharing their birthing experience and those of their tūpuna with myself, and other participants may be younger but have a knowledge base in this particular kaupapa that is superior to mine. They then become the tuakana and I the teina.

Freire (1970) discussed dialectical unity encompassing both subject and object in a “relationship with reality” (p. 158). I see his discussion on dialectal unity to be similar to tuakana-teina, as an awareness of knowledge sharing and power. Freire said that the relationship between subject and object as a dialectical unit could be perceived with consciousness and reality, thought and being, and theory and practice. Freire (1970) highlights that understanding this dialectical unity will help explain the relationship. As an educator, Freire (1970) framed much of his work to elucidate the dialectal relationship between the narrating teacher (subject) and the listening students (objects). Freire argued that the narration style approach of feeding student’s facts and detail without any dialogue failed to contextualise the information. Freire argued that this style of teaching is about “filling the receptacles” or banking knowledge into the brains of students but not encouraging student inquiry that will lead to the student becoming an equal in the subject and therefore empowered.

Any situation in which men [sic] prevent others from engaging in the process of inquiry is one of violence; to alienate humans from their own decision-making is to change them into objects (Freire, 1970, p. 85).

When Western research ethics override or marginalise Māori obligations and ways of doing and being we may see an “oppressor-oppressed” relationship, whereby the institutional expectations supersede issues of cultural safety and cultural responsiveness. An example of this occurred in this research when the concept of koha (gift) was challenged. I was questioned whether offering koha was ethical as it could be perceived as coercing the participant into the study; yet I had always seen koha in these situations as a token of reciprocity (Macfarlane, Personal Communication, March 2016).

To return to Freire and the application of his ideas on the oppressor and oppressed relationships within this doctoral research would be to perceive the oppressor as the academy and the ethics process which students are required to abide by. This includes the justification process that takes place through regular academy reporting. This is to assure the academy that the researcher has the ability to adhere to the academic rules in order to conduct their research appropriately. It is difficult on occasions to find the place and acceptance for cultural ethics within academia. Therefore, in response to the questions posed by the ethics committee, it contained cultural knowledge that aided the ethics committee to understand in more depth the intent and approach of the researcher as an object, and the subject being those interviewed. Creating a dialectal unity enhances the research process and sustains positive outcomes for the participants, their community, the researcher, and the academy. The koha question was laid to rest and duly given to express gratitude post interview.

Kia Piki Ake i Ngā Raruraru o te Kainga – The Principle of Socio-Economic Mediation

This research principle finds initiatives and pathways forward through research processes and outcomes that alleviate rather than perpetuate ongoing and long-enduring low socio-economic status and the associated problems that directly link to inequities for Māori in terms of health, society, and education. Kia piki in this principle means to uplift or improve, while the term ngā raruraru o te kainga is about the challenges some Māori may face within their homes or communities socially and economically. Therefore, this principle centers on research and research designs that attempt to improve the current status of Māori living in impoverished states.

Māori within research, as researchers and as participants, change the research paradigm from the historical status quo when Māori were researched by non-Māori and became objectified. Historically, Māori in research rarely received the benefits of the study they were directly involved with (Smith, 1999). Kaupapa Māori research, according to Hokowhetu et al. (2010), promotes resistance to dominating research processes and simultaneously promoting resilience in the Māori community by changing the perspective to a Māori worldview. This empowers Māori researchers to define their research questions and exercise ownership over the whole research process (Bishop, 2005). Smith (2003) defines the kaupapa Māori praxis as:

A shift away from an emphasis on reactive politics to an emphasis on being more proactive; a shift from negative motivation to positive motivation (p. 2).

Therefore, reclaiming the research reigns has enabled power to be shared amongst Māori involved in the research process and potentially to have a more significant impact on the immediate lives of the research participants and their communities. Māori research by Māori researchers shifts the research scenario of Māori with a problem to Māori with potential, as penned by Mason Durie (2003).

This research leans towards the awareness of identity and cultural knowledge in the hope that it will provide an impetus to grow confidence amongst whānau Māori. That they can birth using the skills that are inherently theirs, and that the recommendations influence the delivery of culturally promoting maternity practices in Aotearoa.

Freire (1970) recognised that knowledge is a tool for power. Often, the crux of social problems is a lack of money or resources to implement initiatives deemed essential to uplift Māori within their community. Research can be leveraged to assist funding applications and make arguments in a language that policymakers hear. In this respect, Māori as researchers strengthen Māori organisations and rūpū (groups) to become more autonomous and can support the growth of service provision for Māori by Māori.

Kaupapa – The Principle of Collective Philosophy

This principle is about honouring whakapapa (family lineage) and whānau through developing a plan, an idea, a proposal, or a research agenda (kaupapa). As the author, I have brought my whakapapa to the research, the research participants, and their whānau. They also brought their whakapapa to the research and the researcher. Connections and bonds are developed that allow the eventual research kōrero to lie upon a whāriki (platform) of respect and understanding. Honouring the gifting of kōrero from the research participant, which is not only theirs but from their whānau whānui, magnified the significance and the beauty of the whanaungatanga (relationships). In a research relationship, neither should have power nor control, but both share a passion for birthing practices and pūrākau (stories). Social science research supports the research relationship and recognises the impact the research can have on multiple layers: individual, local community, national and international public policy. Davies et al., (2005) spoke about knowing the impact of the research findings and directing the research methodology to best include these outcomes as part of the research project.

The decision to further explore birthing traditions for this doctoral study, followed a Master's degree on the same topic. The interest came from learning more about my iwi traditions pertaining to birth. I kept digging metaphorically into this kaupapa to find more knowledge, more resources, and more practices specific to Ngāi Tahu. I sought to contribute through research towards Ngāi Tahu's cultural revival and growth of iwi identity. This reflexive approach to the research has had both a positive impact and, if not acknowledged from the beginning, could have had a negative influence due to an initial tunnel vision approach towards my personal bias (Maxey, 1999). I have explained my position within this research in a preliminary document at the front of this thesis titled, *Unutai au?* and in the thesis introduction (p. 1 & 2)

I align myself within this doctoral study alongside Ngāi Tahu and Māori midwives from other iwi to ensure I am researching and writing with their support and guidance. I am a senior registered nurse with over 20 years of nursing experience in the community and clinical settings. I have nursed in a wide range of health specialties and with four District Health Boards. My personal interest in this kaupapa, as a mother and health professional, aided the commitment required for this knowledge inquiry.

I established the rōpū kaumātua (Māori advisory group of Ngāi Tahu kaumātua) to specifically provide cultural support and wisdom throughout this study. Their thoughts and interpretations of the research were often more worldly and expansive than my views. They brought more insightful thinking and experience to the interpretation of the findings. Also, regular supervisory discussions wove other considerations into every component of the research process (O'Reilly, 2009).

This doctorate sits alongside a wider cultural resurgence kaupapa for te iwi Māori, with an emphasis on Ngāi Tahu cultural aspirations and their intent for a cultural revival. Te Rūnanga o Ngāi Tahu has outlined the need to protect Ngāi Tahu whakapapa and their relationship with the land and sea. Ngāi Tahu's Māori language strategy, Kotahi Mano Kāika, aims at revitalising Ngāi Tahu language, and more effort has been applied to further develop the Cultural Strategy, titled *Manawa Whenua, Manawa Reo, Manawa Kāi Tahu* (Our World, Our Word, Our Way) (Te Rūnanga o Ngāi Tahu, 2017). Colonisation had a spiritually and physically demoralising effect on Ngāi Tahu. Some tūpuna were able to grasp hold of the Western offerings whilst retaining their reo, tikanga, and standing in te Ao Māori. However, most did not, and today we are still scraping the surfaces of a rua (hole) that allows us to glimpse into te puna mātauranga (the pool of knowledge), but the journey to recovery will be long lasting, and not always easy to comprehend (Anderson, 1998; O'Regan, 2014; Waitangi Tribunal, 1991).

Te Rūnanga o Ngāi Tahu has developed cultural growth strategies, as outlined in the report by Reid, Rout, Tau, and Smith (2017). Their research project looked at the aetiology of the trauma imposed on Ngāi Tahu whānau through colonisation, and how Ngāi Tahu have employed coping strategies to overcome historical trauma. The lengthy submissions to the Waitangi Tribunal resulted in several reports, such as the Waitangi Tribunal Ngai Tahu Report in 1991, the Sea Fisheries Report in 1992, and the Ancillary Claims Report in 1995. All acknowledged the failure of the Crown to honour Ngāi Tahu

and urged the government to act swiftly in settling the wrongs of the past and repay the debts it owes to Ngāi Tahu (Waitangi Tribunal, 1991). The “kaupapa” of Ngāi Tahu birthing practices and ritual is a component of an even larger kaupapa of cultural revival to regain, reteach and retain our tikanga and mātauranga that has been forgotten.

Cultural pride is linked to the opening of knowledge pathways that are intrinsic to us all and can bring great satisfaction when they are unlocked. Like Ngāi Tahu’s te reo Māori language strategy, *Kotahi Mano Kāika, Kotahi Mano Wawata (One thousand Homes, One Thousand Aspirations)*, a strategy that focuses on the intergenerational transmission of te reo Māori (Potiki, 2010).

Te Tiriti o Waitangi – The Principle of the Tiriti o Waitangi

This principle shares a common bond with the Tino Rangatiratanga principle, as discussed previously. It also looks more closely at the importance of the Treaty as a whole and the role that it plays in forming and recognising relationships between the Crown and Māori Treaty partners. Pihama (2001) argues that Te Tiriti o Waitangi (1840) is a vital document that continues to provide a platform through which Māori may “critically analyse relationships, challenge the status quo, and affirm the Māori rights” (n.p.). The experience and implications of Māori negotiations with Pākehā and Treaty settlement with the Crown were described in the literature review under Te Tiriti o Waitangi and Ngāi Tahu and Te Kerēme; the implications continue to shape Māori today and can be felt in the origins and practice of kaupapa Māori research.

The reclamation and restoration of Ngāi Tahu knowledge and practices pertaining to conception, pregnancy, and birth in this research project are intended to be a contribution towards this significant healing journey for Ngāi Tahu and those who died in the vindication process with Te Kerēme. To utilise the strength of my forebears to rectify the wrongs supplies this doctorate with the kaha (strength) and the direction to explore creation philosophy from a healing perspective.

Ata – The Principle of Growing Respectful Relationships

The ata principle in kaupapa Māori research permeates through all other guiding principles discussed so far, in all actions and all phases of the research process. It means

to form or shape, but more holistically; it refers to things that are tangible and intangible, that are spoken or non-verbal and sensorial things.

To carry out the principle of *ata* is to commence a relationship of mutual respect and trust with research participants as well as all peoples involved with a research project, including colleagues. A relationship that fosters respect and encourages honesty from researchers is vital. The objective is to encourage and evoke positive interest by the participants, who may then feel safe to share their life stories and knowledge (Pohatu, Pukeiti & Naera, 1999).

Ata is also about having respect for the project and the participants through careful and diligent planning of the research. It is about being transparent with intentions and actions. It is similar to the concepts of *Ata pō* (early morning darkness), *Ata tū* (just after daybreak), *Ata pongipongi* (daybreak), and *Atarau* (moonbeam). All terms issue clarity and light to a place and space through a phase in time. Such terms bring richness to the research and remind researchers of the research intent, and the privilege, not a right, to obtaining participant narratives (Pohatu, Pukeiti & Naera, 1999; Smith, 1987, 1997).

Ancestral links and, in particular, my *tūpuna* have guided this research; primarily, Teone Tikao (my great grandfather). His teachings were collated in manuscripts, in *waiata*, in government minutes and royal commission enquiries and discussed in the book titled, *Tikao Talks*, by Herries Beattie (1990). Tikao spoke about creation stories, *tikanga* (customs), *kawa* (protocol) and *mātauranga* (knowledge) specific to Ngāi Tahu, Ngāti Māmoe and Waitaha whānui. He was honest about what he had learnt from *tohunga* and other elderly experts, and what he knew little about. His understanding of the creation story differs significantly from the northern *iwi*. However, it is this difference of perception and interpretation that evoked a curiosity to explore Tikao's teachings of creation further (Beattie, 1990). On the beginnings of the universe, he wrote:

Once there was nothing but water. The sea covered the whole earth and lay like a vast, unbroken lake within the circle of the sandbank that ran right around it. There was no land and no sky, no sun, nor moon, and no stars, nor clouds. Darkness reigned (Beattie, 1990, p. 23).

This project concerns the reclamation of birthing knowledge inclusive of wāhine Māori as powerful leaders and mothers. Kaupapa Māori acknowledges Papatūānuku, the Earth Mother, the universal mother, and her tūrangawaewae on this whenua (land); she is the layering within the word kaupapa and physically upon the topography of the land. As a Ngāi Tahu wāhine, I see the world through my tribal lens, as a hākui (mother), as a tauira (student), as a kairangahau (researcher), as a kaimahi hauora (registered nurse) and all these roles influence the application of kaupapa Māori theory in this research.

3.2 Section Two: Methods employed in this research

In this section, I discuss in more detail the methods used to gather research data, which include research interviews and wānanga Marae (focus groups held at marae) and other repositories of knowledge, such as pūrākau (stories) and visual and digital media. The kaupapa Māori methodology is applied to the practice of researching in this section. This is discussed in relation to practices such as how the participants were identified according to their consent and ensuring the authority of the research participants is upheld in terms of knowledge ownership and interview archiving.

The gathering of knowledge was through a variety of methods in order to weave a narrative of Ngāi Tahu customary birthing practices. As this traditional knowledge has mostly been forgotten, retrieval relied on activating many different repositories. One site of knowledge could not provide all the mātauranga I was seeking; therefore, several approaches were engaged in order to quantify the research. I have outlined each below.

Research Questions

The literature discusses the hospitalisation of birth as a colonial tool that assimilated Māori through the enforcement of western medical practices, under the guise of better health and reduced infant mortality (Banks, 2000; Donley, 1986; Papps & Olson, 1997; Stojanovic, 2010). When birth moved out of the home and local pā (Māori village) and into birthing rooms and hospitals, what also left was the practice and expression of customary Ngāi Tahu birthing rituals (Harte, 2001). The implications are seen today, where only some mothers and whānau have this customary knowledge. Very few whānau practice this knowledge, and many do not feel confident and competent to pass on this customary knowledge. Therefore, this research project was designed to explore the decline of Māori creation rituals and practices, with the hope that discussions with kaumātua, Māori midwives and archival research may assist with their return to birthing plans and birthing experiences.

In the initial stages of planning for 29 semi-structured interviews, I began the task of composing a series of questions to match the six groups of interviewees:

- Kaumātua and whānau
- Māori artisans: kairaranga and kaiwhakairo
- Māori kaitiaki o mahi toi ana (custodians of Māori arts)
- Māori midwives
- Māori midwifery students; and
- Lecturers of the South Island Midwifery programmes.

The questions asked of the research participants can be viewed in Appendix D (i).

The questions posed to the kaumātua were situated around their birth experiences. How they prepared for their pregnancy and birth, where they birthed and why they birthed there. Rongoā they may have used and how was it used, rituals they may have experienced and their understanding of why these rituals were undertaken. Also, if they knew could share any karakia and/or waiata associated with creation or birth.

The questions for the Māori artists and those who looked after taonga Māori were orientated around the symbolism of the art they crafted and cared for. What symbols they align with creation in their medium of work and what symbolic meaning their art expressed. I directed these questions to Māori artists who worked with whakairo (carvings), raranga (weaving), tukutuku (latticework), kōwhaiwhai (rafter paintings) and toi toka (rock art).

I addressed the Māori midwives, Māori midwifery students and the midwifery lecturers with questions about the Māori content within the Bachelor of Midwifery curriculum, particularly regarding Ngāi Tahu traditional birthing practices. The second tier to their questions focused on the Māori midwifery students and how to lure more to the midwifery profession and support them whilst establishing their midwifery careers.

The qualitative interviews were conducted where the research participant felt most comfortable or was convenient for them. The interview approach was warm, relaxed and conversational. Two larger group interviews were held at two Ngāi Tahu marae that followed a similar approach after the pōwhiri (formal welcome), with the sharing of stories to evoke memories and more stories from the whānau.

Qualitative Research

Qualitative research is a systematic inquiry which, according to Astalin (2013), describes the narrative holistically to aid the researcher's understanding of a social or cultural phenomenon (p. 118). Qualitative methods are a natural way to capture data, and in doing so, it is understood that there are many versions to a story and multiple realities for the same person being interviewed. This is true for this doctoral research project examining customary birthing practices under a kaupapa Māori approach, which Henry and Pene (2001) aptly describe as:

set of philosophical beliefs and a set of social practices (tikanga). These are founded on the collective (whānaungatanga) interdependence between and among humankind (kotahitanga), a sacred relationship to the 'gods' and the cosmos (wairuatanga) and acknowledgement that humans are guardians of the environment (kaitiakitanga) (p. 237).

Henry and Pene (2001) state that the values mentioned above inform traditional Māori ontological beliefs about what is true for Māori. Kaupapa Māori ethics and philosophy also “drive Māori epistemology, in terms of living according to tikanga, which is tika (true)” (p. 237). Kaupapa Māori in qualitative research shapes our understanding of what is real and what is true; and this then influences our understanding of what constitutes science (Henry & Pene, 2001). I discuss kaupapa Māori theory and approaches further in the next section.

Pūrākau (stories) about creation and whakapapa feature strongly throughout this thesis. Qualitative research, as a method of capturing knowledge, allows for more freedom of expression. Pūrākau can be viewed and articulated in several ways relevant and pivoted to the iwi of the storyteller. Iwi variations of the same pūrākau are natural, valid and easier to capture in qualitative methods as opposed to quantitative research. Quantitative is an empirical investigation of data that gathers measurable or numerical information, to be able to quantify the research variables (McMillan & Schumacher, 1993, p. 12).

McMillan and Schumacher (1993) use the term “inductive process” to describe the categorisation of qualitative research data and the relationships identified between the categories as a further offering of information (p. 479). Astalin (2013) accepts that

knowledge emerges organically in qualitative research, and the critical variables can be viewed more honestly in their natural context. However, Karagiozis (2018) would argue that the subjectiveness of the researcher influences the analysis of study findings; their own life experiences, beliefs, and worldviews. Crewell and Miller (2000) concur that the validity of the research is dependent on:

What governs our perspective about narratives is our historical situatedness of inquiry-based on social, political, cultural, economics, ethnic and gender antecedents of the studied subject (p. 26).

Within this research project, my own experiences as a Ngāi Tahu wāhine innately drive my interest and perception of the research data. Equally, my own birthing experiences with customary birthing practices bias my lens. I look favourably towards customary birthing practices, and in doing so, I may potentially disregard knowledge that speaks the contrary (Braun & Clarke, 2013). However, Bogdan and Biklen (2007) endorse subjective researcher experiences when they claim that qualitative research seeks a person's view of their world or reality; how they interpret their lives in order to learn from a personal perspective. Behar (1993) contends that, as researchers, we ask a great deal from others but reveal little about ourselves. Researchers can exacerbate the vulnerability of the research participant while

Holiday (2007) described the state of the researcher while conducting qualitative research as an interactive process in which the researcher tries to unravel the themes in the data, while at the same time becoming reflexive of their position and role within the research. Aull-Davis (1999) supports Holiday's description when she writes specifically about reflexive ethnography and its practice as a reflection of social reality. She argues that all researchers are connected in varying ways to the heart of the research they are conducting.

Data Collection

The data collection within this thesis, while embracing kaupapa Māori principles, was inspired by the diversity of approaches in ethnographic research. Ethnography is a particular design of qualitative research. It is derived from anthropology and is concerned with studying the fundamental and social relationships of humanity. It describes the intricacies of human societies explicitly to provide a rich insight into

peoples' lives through interviews and observation (Reeves et al., 2008). The ethnographic elements of the research are particularly evident in the interviews and discussions that took place over several months.

The group interviews and presentations conducted at two Ngāi Tahu Marae allowed marae kawa to be followed. Whānau who attended felt comfortable to take part in a research presentation and interview on their marae. Interviews for research are shaped by the connection between the researcher and the research participant and, according to Karagiozis (2018), research participants should be “co-researchers” rather than “objectified objects” in qualitative interviewing (n.p). The influence of ethnography is also evident in the field notes I wrote after interviews describing the context of the interview and details missed on the digital recordings. This research has been like an unfurling frond whose essence I have gradually been able to grasp from the information gathered in its entirety throughout my fieldwork. Specific data sources are discussed below:

Oral: Public archives included recorded radio interviews and documentaries from Radio New Zealand Archives; recorded waiata and karakia; from Ngā Taonga Sound and Vision; and New Zealand Music, Sound, Audio-Visual collection. I gathered stories recorded about well-known Māori individuals and their upbringing that included details of their births, radio documentaries and oral histories about Ngāi Tahu kaumātua and their upbringings from Radio New Zealand archives and Te Rūnanga o Ngāi Tahu's research department.

Pūrākau: These are an essential tool of indigenous qualitative research because the stories go beyond telling a tale and contribute to a collective story in which everyone has a role or a place. Russell Bishop (1996) states that the mana and power lie with the storyteller, not the interviewer. Stories in this thesis come in the form of waiata, kōrero tawhito (old Māori accounts), kōrero maumahara (reflections or memories) and stories captured in Māori symbolism or within the many mediums of Māori art.

Literature: Manuscripts; literature; research papers; historic conference papers and newspapers; letters; examples of waiata and karakia from the Alexander Turnbull library in Wellington the Hocken and McNab collections in Dunedin and the McMillan Brown University of Canterbury library in Christchurch were retrieved. My initial

search for related literature commenced with a wide approach, conducting topic searches under customary Māori birthing practices, Māori birth, childbirth and maternity. Information was gleaned from these sources about Māori life as lived by Māori or as observed through missionaries in their church journals, letters, or publications. Historical newspaper items followed the updates on the Tohunga Suppression Act in 1907 or mentioned who had been charged for practicing as a tohunga, the naming of Māori children after significant events, and the increase in Christianising names (such as Ripeka, Karaitihana, and Anahera). Otago University medical students in the 1940s provided interesting case studies on Māori villages, often in the North Island, but the knowledge they provided in their unpublished research aligned with other similar stories from Ngāi Tahu about birthing and raising children on the pā. I placed the relevant literature into bulk sections relating to the chapters. There were folders for: creation narratives, customary birthing practices, midwifery practice and midwifery training, and Indigenous birthing related readings or books.

Visual: Film and television archives; paintings produced by early artists/historians/ethnographers; and the symbolism within the rock art drawings, whakairo (carving), kōwhaiwahi (rafter painting), tukutuku panels (latticework) and mahi raranga (weaving). The visual sources provided an aesthetic of creation symbolism often portrayed in the above art mediums. Some symbols were repeated across all art forms, and other symbols were unique to one art form. The placement and non-placement of symbols provided more depth to the creation story it was portraying (Mead, 1995; Mulholland & Bargh, 2015; Phillips, 1941). I researched material from Ngā Taonga Sound and Vision and the New Zealand Music, Sound, Audio-Visual collection and viewed artwork online and in the galleries of Māori artists.

Semi-structured interviews: In semi-structured interviews, the researcher asks the interviewee predetermined questions based on kaupapa (topic) sections. However, the interview itself can be conversational and allow the interviewee to contribute their thoughts that are not included in the question set. The use of a semi-structured interview allows for flexibility in the interview and the flow of dialogue between interviewer and interviewees (Drever, 1995). I constructed a series of questions that were closed and open-ended. I could seek further elaboration from the interviewee with simple prompts, for example, “can you tell me more about that?” or “why did you think that?”.

The semi-structured interview style aligns effectively with a kaupapa Māori approach. As it is more conducive to a flow-style of kōrero (speak) in the interview, especially if the interviewee wants to talk whakapapa, Marae “politics” and a recent tangi. This relatability between researcher and research participant acknowledges the kaupapa Māori research principles, such as Ata, Kaupapa and Taonga Tuku Iho. Many times, the participants in this study and previous research projects will claim they do not know about the kaupapa, but throughout the interview, their knowledge shared is beyond my expectation. This revelation is due to the interviewee feeling more comfortable with the interviewer, more connected and more confident with what they can contribute to the research, and perhaps understanding more as the interview unfolds what is being asked of them. Therefore, as the layers within the kaupapa of the research and the kaupapa of the methodology are exposed through a semi-structured interview process, the interviewee are inclined to share more.

Generating tautoko (support)

Rōpū Kaumātua

I established a small kaumātua rōpū (a research support group of Māori elders) to tautoko (support) the research and to provide guidance on cultural protocols. Situating the rōpū alongside myself presented a stronger collaborative approach that felt tika (right) under a kaupapa Māori framework. I maintained contact throughout the research with the rōpū kaumātua via cards, letters, emails, phone calls, and kanohi ki te kanohi (face to face) on how the project was progressing, and to seek their thoughts on the research content. I had kaumātua attend the two Marae wānanga and attend other presentations on my thesis topic. They provided a grounding component for me and the research kaupapa.

Recruitment

Community participants were identified via communication with key consultation groups, such as the Māori Women's Welfare League and the Ngā Maia Māori

Midwifery Collective, via presentations about the research between 2016 and 2018 in Dunedin, Christchurch, Wellington and Hokitika. Potential participants also responded to my pānui/advertisements placed in Karaka (the Ngāi Tahu Iwi magazine) and Te Pānui Rūnaka (the Rūnaka newsletter). I had a calling card and poster, such as the one below that I distributed at conferences, hui and wānanga.



Fig.3. Promotion Research Card/Poster for doctoral research – Kelly Tikao

I also contacted the individual Rūnanga to email my advertisement out via their electronic networks to recruit participants and to advertise the upcoming wānanga (screening and kōrero). Once a potential participant's name had been passed to me by their whānau member (after their whānau member had obtained consent for their details to be passed on), I provided information sheets and consent forms. I would then ask if they would be interested in participating in my research. The local Rūnanga offices and kaimahi (workers) in the Rūnanga became vital conduits to accessing members and communicating my study. This was made easier by being of Ngāi Tahu whakapapa; being able to whakapapa to several Rūnanga further aided the research promotion.

Having affiliations to Marae can, and did in this research accelerate the recruitment process.

Arrangements for an interview were made following the participant's acceptance and a date, time, and location of a kōrero was confirmed. I then kept in contact via email to keep them informed of where I was at with my research and I also gave gentle reminders of the date(s) set for their interview. Regular communication was also a rapport-building exercise; getting to know my participants and them learning more about me. By keeping the participant updated with brief emails enabled me to establish an open and trusting relationship, and ensured that participants remained connected to the study.

In summary, the following media networks were utilized for participant recruitment:

- Te Rūnanga o Ngāi Tahu website
- Karaka Magazine
- Te Pānui Rūnanga
- Rūnanga Electronic Networks
- Mana Magazine
- Selected Māori health providers, i.e. Te Araiteuru Whare Hauora and Ngā Maia o Aotearoa (National Māori Midwifery Collective)
- Māori Community Providers i.e. Māori Women's Welfare League, Māori Media, Māori Health Providers in Te Waipounamu, Māori kura in Te Waipounamu (Māori language immersion school newsletters) and Tahu FM (Ngāi Tahu radio station in Christchurch).

Research interviews

Individual semi-structured interviews were conducted that were in-depth, open-ended and explorative (Thorne, 2000). I offered participants the option to express themselves in te reo Māori during the interview process. This choice was to honour an official language and participants who preferred the interview in te reo Māori. Andrews (1995) advocates that the native language of the interviewee should be used to gain trust and to develop rapport. Tsang (1998) concurs that having the researcher understand and be able to converse in the native tongue of the research participant creates a favourable

environment and potentially gains greater access to the interviewee's life and experiences.

The first phone call to the research participants took between 5–20 minutes. This initial conversation allowed me to understand how much they knew about traditional Māori birthing practices and rituals, how comfortable they were to share this information with me, and whether they consented to be interviewed or not. The qualitative interviews took an average of two hours, with 70 minutes of the interview recorded. Some of the interviews were completed in one interview sitting, and others were shorter with recurrent visits up to three meetings. I was open to being guided by my hosts and participants. The first part of the interview involved rapport building, a mutual inquiry into whakapapa, a linking to connections and then, after this had taken place, the formal research questions would begin, and the interview would be recorded.

In total, I interviewed 29 individuals consisting of 24 Māori and five Pākehā. Twenty-one affiliated with Ngāi Tahu. Eleven participants represented maternity services in Canterbury and Otago, which allowed for the clinical questions concerning the acceptance and practical application of traditional Māori birthing practices in maternity services.

For the professional health participants, I conducted three solo interviews with Māori midwives and a group interview consisting of four midwifery lecturers. The research aim for these interviews was about the reality of incorporating traditional Māori birthing practices in midwifery education. How this knowledge may relate to the midwifery students' approach to whānau Māori and their ability to assist whānau Māori engage with traditional practices. I needed to see if there were any discrepancies between the lecturers, midwifery education directors and the Māori midwifery students. The intrigue was whether there would be any insight by either side to understand the importance of customary birthing practices to the overall hauora of whānau Māori and, if so, how this would connect to the current midwifery curriculum and recruitment of Māori midwifery students.

I presented my master's and doctoral research at the Ngā Māia Māori Midwives Annual Hui in September 2016 and ran a workshop for Māori midwives interested in contributing to the 'take' (topic) of the research. Some of those who attended took the

time to read the information sheet and to sign the consent form. This highlighted their interest in being involved; these people were followed up for a research interview. Due to financial constraints, I was unable to interview all who had indicated their interest in being involved. Although the initial intention was to conduct a semi-structured group interview, this did not take place due to the time constraints of this hui. What was gained instead, was a vast network of Māori midwives and midwifery students from around the country and the chance to scope their knowledge and capacity to deliver traditional Māori birthing practices to whānau Māori. The wealth of knowledge about maternity, whānau ora (family wellbeing), hauora Māori (Māori wellbeing), te reo Māori (Māori language) and tikanga (customs) was evident in crucial wāhine and tane, and for others, this knowledge was new and exciting.

For community participants, I sought Ngāi Tahu kaumātua to contribute to this project. The selected kaumātua were recommended by their Rūnanga and/or whānau to be part of the research. Time was spent engaging with whānau to outline the research project and the information I was seeking. All whānau showed an interest in the kaupapa, and kaumātua contacted me because they were initially intrigued and often eager to share their birthing knowledge. Issues encountered in undertaking the kōrero were, as discussed above, concerned with knowledge limitations and loss. Due to the knowledge requested being forgotten by many and vague to others the interviews took longer to conduct. However, participants sometimes recalled snippets of whānau stories when triggered or inspired by something said in our conversation or prompted by images or a known kōrero from the area.

Wānanga/Focus Group Sessions

The term wānanga is a place and space to gather, talk, reflect, and impart tribal knowledge. I used these wānanga to present what I had learned about my doctoral kaupapa and how I intended to conduct this doctoral research project. I also utilised the wānanga to glean information from those who attended, and to recruit participants. I facilitated two wānanga; one at Te Hapū o Ngāti Wheke in Rapaki, Canterbury, and the other at the Arahura Marae, Awatuna, West Coast:

2016 – February 21st, Te Wheke Marae and March 19th, Arahura Marae.

Royal (2014) claims that mātauranga Māori belongs in wānanga. It is in wānanga that mātauranga Māori is researched and taught. Therefore, holding wānanga inclusive of presenting and teaching knowledge is also a vehicle to seek stories and experiences from those who attend. Royal (2014) states that the wānanga process activates a person's mana atua (sacred spiritual powers), which reflects the qualities of the natural world. Activating someone's mana atua is to facilitate their oneness with the natural world. In terms of running wānanga, a kaupapa Māori approach was sought to awaken memories that may have been lying dormant for many years and once prompted more information may be released.

I advertised the hui through various Rūnanga contacts (see recruitment section below) and kept in close contact with the Rūnanga office to rally up interest and to remind whānau that this wānanga was taking place. Utilising the principles of kaupapa Māori research, for instance, tino rangatiratanga, taonga tuku iho, ako, kaupapa, and ata, I commenced the facilitation of the two wānanga. A team approach was arranged to provide cultural support from the rōpū kaumātua as kaikōrero at the pōwhiri and alongside me through the wānanga, a kairaranga (weaver) and a kaimahi taonga pūoro (traditional Māori musical instrument performer) assisted with workshops throughout the wānanga. The wānanga at Ngāti Wheke commenced with a mihi whakatau (informal ceremonial welcome), which morphed into an information session. As people stood, they started their pepeha (tribal saying) and, with this, their pūrākau (stories) and interest in this kaupapa and why they wanted to be there flowed naturally. At this point, I recognised that the mihi whakatau and pōwhiri are creation methodologies in themselves; they welcome, they lay the foundations for the day and the kaupapa, they create a safe space for us to be in, and they feed us mentally and physically.

Arahura had a pōwhiri (formal welcome) for the second wānanga, and our karanga (calls) were joined by the sounds of the taonga pūoro (traditional Māori musical instruments) being played by a taonga pūoro artist, Mahina Kauī, as she walked with us in the ope manuhiri (visiting group). Manu tioreore (singing birds or the kaikaranga female callers) were acknowledged by the kaikōrero (speakers) on the paepae (speaking platform). The speakers acknowledged how right and how magical it was to hear both

the karanga from wāhine and the karanga from the taonga pūoro calling out across the ātea (front section of the wharehau).

The inclusion of kēmu Māori (from the whare tapere – entertainment house) were introduced in the wānanga to bring the rōpū together and to transcend headspaces to the times of our tūpuna (ancestors) (Potiki-Bryant, Personal Communication, December, 2015; Royal, 2011). At Ngāti Wheke marae, the singer and historian Ariana Tikao performed and presented the origin narrative of taonga pūoro (traditional Māori instruments) to the participants. Mahina Kauī did a similar presentation at the wānanga in Hokitika. Both spoke intensively about the role of taonga pūoro in creation by describing the origins of many of the instruments they played and displayed. Key snippets were screened from my student film, *Iho – a cord between two worlds* (produced as partial fulfilment of my master's degree) to both wānanga, followed by a discussion with the participants that took the form of hearing their stories, answering their questions and asking what they may know about this research kaupapa.

The wānanga concluded by making whītau muka (muka cords that can be used to tie the pēpi's umbilical cord). Rānui Ngarimu, who is a member of the research rōpū tautoko (kaumātua advisory group), provided ongoing guidance to my research project by attending wānanga, taking phone calls from me with various questions concerning symbolism in weaving, and other matters relevant to my research kaupapa. We had a kairaranga (weaver) ready to go at the wānanga at Arahura, but we ran out of time due to other areas of the wānanga going over time. Getting behind in the schedule was not seen as a disappointment but more so as a tohu (sign) of people eager to learn about this kaupapa and the time it took to get through the first part of the programme.

The rationale to include taonga pūoro and muka whītau was to utilise tactile and sensory experiences to open memory channels and encourage any thoughts or memories to come forth. It was also important to encourage those who may feel they had nothing to share but would like to be involved. Additionally, it was important that something was reciprocated to those who attended, something practical that they could keep for themselves or give to other interested whānau members. Small kete were given as a koha with each containing: a piece of obsidian (matā); a mussel or a pipi shell (kūtai or kuku) both used as maripi (knives); a piece of hoanga (sandstone); and a muka whītau (muka cordage to tie umbilical cord). These rauemi (resources) provided, were in

essence, a starter kit for traditional birthing tools. The muka whītau is used to tie the umbilical cord between the pēpi and their placenta (whenua). The matā or kūtai shell is a knife to cut the umbilical cord, and the kūtai shell remains sharp by rubbing the kūtai shell along the hoanga or sandstone.

Anonymity

Researchers Pere and Barnes (2009) raised a pertinent question in an article they wrote, titled *New Learnings from Old Understandings asking, “Whose Anonymity?”*. I have observed in research projects at the Donald Beasley Institute, along with my post graduate study that some Māori and people with learning disabilities want to have their names associated with their stories. They seem to grapple with the concept of not naming their narrative. In contrast, maintaining confidentiality is primarily to protect the research participant and their families. However, this necessary clause in research sits in the hands of the researcher and not those being researched. Pere (2009) questioned whether confidentiality was, in fact, culturally appropriate in some circumstances due to it potentially “discounting local mana” (p. 11). Māori participants often want to have their name and their iwi next to their interview stories as an expression of mana motuhake, claiming their story, and do not seem over-concerned with the research ethics that remain super vigilant to keeping people anonymous. However, some Māori participants want to highlight that their knowledge has been passed down from their whānau to them, or learned through their hapū or iwi connections. Therefore, by not disclosing the source offers no mana to the origin of the kōrero, and a sense of disrespect from the research participant can be generated by not honouring the kōrero they have shared (Pere & Barnes, 2009).

In this thesis, research participants were given several options in terms of disclosure of name, iwi, or to remain anonymous, as indicated in the excerpt from the consent form below. It is interesting to note of the 29 research participants for this study, only one requested to be anonymous.

Identification

I agree to the following identification in all written documentation associated with this research:

✓ *Please tick the correct box*

- ☐ My name and iwi
- ☐ My name only
- ☐ My iwi only
- ☐ To remain anonymous

The irony of obtaining anonymity is that it can also restrict the extent of the knowledge gathered or restrict the interest of Māori to participate if they feel they cannot rightly honour the knowledge by identifying themselves or the knowledge origin. This then begs the question, who is anonymity for and to what purpose? Is anonymity to protect the research participant or the researching body? (Pere & Barnes, 2009; Sharples, 2001). Kaupapa Māori research has become widely accepted in New Zealand as a valid research tool, yet more work needs to be done around the inclusion of Māori ethics based on Māori value systems to be able to deliver kaupapa Māori research in its entirety and not just as a component within a mainstream framework.

Returning Interview Material

Sharples (2001) spoke of the importance of tikanga in the research process, the expression of tino rangatiratanga (chieftainship), in terms of validating a Māori research process and keeping the voice of Māori forefront in research about Māori. For Māori researchers navigating their way through a dominant non-Māori academy of learning and following their research, ethics and instructions can sometimes clash with the personal ethics of the group being researched. Two examples of this include the confidentiality clause and the discarding of the raw data, such as the interviews or transcripts, after ten years. For me, as a Māori researcher investigating the research question within my iwi, the disposal of data is not something I have the right to do. The information shared with me in interviews does not belong to the academy or me. The

participants gave permission to use their interviews with the expectation that, upon completion, I would return the interview/kōrero, material/transcripts. In the consent form, several options were provided with the intent that data gathered would be returned to the participant, to someone else, or be held at a place that they wanted it to be deposited within. My consent form contained the following clauses regarding data “disposal”:

Disposal of Data

I agree to the following options in regard to what will happen to my recorded data, including photographs and film footage, after the mandatory ten years of storage preservation:

- ☐ My data, inclusive of photographs and/or film footage, will be sent back to me at the above address.
- ☐ My data, inclusive of photographs and/or film footage, will be gifted to the Hocken Library (Dunedin) as an archival repository accessible to the public for research.
- ☐ My data, inclusive of photographs and/or film footage, are to be disposed of.

An arrangement was also made with the Hocken Library in Dunedin to store the interviews and transcripts that consented to this option would be transferred onto a Hocken Library preferred digital medium and kept private (for whānau and myself to access only) for ten years post completion of the doctorate and then made available to the public. This appeared to be a suitable solution to ensuring Māori archival material was not destroyed but contributed to the growing inventory of Māori knowledge on this kaupapa.

Retaining tikanga Māori, such as ownership and the restoration of tribal knowledge, as mentioned above, I believe, contributed to the study aligning with the kaupapa Māori approach and addressing the goal of strengthening knowledge of traditional Ngāi Tahu birthing practices. This section highlighted the many methods utilised to investigate what knowledge still exists on this given kaupapa, and the next section explores the approaches used to analyse the findings.

3.3 Section Three: Analytical Approach

I utilised reflexive thematic analysis under a kaupapa Māori perspective to analyse the data contained within the research interviews, field notes, and a wide array of literature, including karakia, waiata, and Māori art forms. Reflexive thematic analysis critically examines an experience in relation to the objectives of a particular study and is an important cognitive practice that legitimates and validates research procedures (Aull-Davis, 1999; Braun & Clarke, 2019; Davis, 1999).

Reflexive thematic analysis is adaptable and can be used with other research frameworks, such as kaupapa Māori research. Both reflexive thematic analysis and kaupapa Māori research are organic and adaptable, and both acknowledge the role of the researcher within an interactive process. I am a kairangahau Ngāi Tahu (Ngāi Tahu researcher) who is a wāhine and hākui (female and a mother), seeking knowledge about my iwi Ngāi Tahu. Who I am is poignant to the gathering and the analysing of the data-set.

I transcribed a number of the scripts and read each transcript many times to familiarise myself with the content. It was reading over the transcripts that allowed for incorrect Māori words or sentiments to be corrected by ear, and by referencing the interview audio. I sought professional assistance to speed the transcribing process up. Unfortunately, there are very few transcribers who can transcribe Māori; therefore, all professionally transcribed interviews had to be checked not only for accuracy but to correct the Māori language spelling and context. This was a lengthy process but did ensure I listened to the interviews multiple times, which allowed me to discover more information that became more and more relevant to the research as it progressed (Jorgenson & Phillips, 2002). It is intriguing and rewarding upon returning to the dataset after time away to discover more knowledge, details, angles, aspects or, even within the pauses; something missed either at the moment or while transcribing. This is similar to the acting technique referred to as the Sanford Meisner Acting technique, which allows a stillness or silence from which one can ponder on a thought. This space allows another thought to rise or to realise (Foster, 2000). Reviewing the data and listening to the interviews again revealed statements that had not been previously

picked up, or perhaps more time was given to listening to the participants' answers and having more reflection over their comments.

I also attempted to translate some of the *karakia* and *waiata* to obtain an understanding of these *taonga* (treasures) and sought wisdom from Ngāi Tahu te reo Māori and *tikanga* experts to oversee and correct the translation where appropriate. *Karakia* and *waiata* were either already translated within the retrieved text by the author or have been translated by either myself or by an arranged translator. Many of the *karakia* are not completely translated but given a summary to aid comprehension. This process took considerable time and respect to just begin this process. Old texts will always be up for varying interpretations and what I have written in this thesis was never intended to be conclusive.

I utilised a discourse analysis to examine the text and language in relation to their social context. This form of inquiry considers how the language conveys messages by investigating language patterns across the text. Combined with verbal expression these modes of discourses can gain a greater comprehension of the relationship between language constructs connected to the socio and cultural context (Paltridge, 2012; Snape & Spencer, 2003; Weiss & Wodak, 2003).

Discourse analysis in kaupapa Māori research can comprise of other forms of communication. For example, the discourse of *toi* Māori (Māori arts) includes the sharing of information through symbolism. This comprises of interpreting the meanings of symbolic patterns, such as their location on the art form, how bold or subtle they are and perhaps the intertwining of other symbols. Other discourses may include *karakia* (incantations), composed and sung *waiata* and *taonga pūoro* (traditional Māori musical instruments) that emit sound, vibration and pattern sequencing. Investigating the discourse of *toi* Māori provides another avenue for meaningful enquiry in child birth (Archey, 1933; McLintock, 1966; Marsden, 2003; Mead, 1995). Gonzales (2012) also spoke of hidden codes within Mexican Indian arts, stories and tribal ceremonies that embed layers of tribal history and knowledge. These are Indigenous discourses that provide intrinsic detail about people and their identity.

Discourse analysis is also conducive to capturing the nuance of te reo Māori and the Ngāi Tahu dialect in the research interviews, with tribal references or sayings associated with Ngāi Tahu; participants' sayings distinctly identified their hapū or iwi,

or located them geographically in Aotearoa. An example of this, was the use of the K instead of the NG in the Ngāi Tahu dialect, of the use of “kaik” for village or pā shortened from kaika (or “kainga” as expressed amongst most North Island iwi regions).

Once I was familiar with the interview and field note material, I began to code the data to identify reoccurring patterns or subject matter within the data. This was a labelling process using a colour coding system that aligned different colours to different ideas. The ideas that were highlighted began to form the basis of potential themes. I had 43 codes allocated during this process and, from these codes, 20 initial themes were generated. Braun and Clarke (2006) emphasise that, although thematic analysis looks at the instances where something is mentioned across the dataset, this does not necessarily mean a particular theme is more “crucial” than another theme (Charmaz, 2006; Saldana, 2009). Regarding a semantic or latent thematic analysis, it was thought that the dataset was situated in the latent and more interpretive level. The participants spoke on multiple levels on the same theme. For example, they spoke of spirituality, mythology, physicality, and sociology, all within one answer to one question. It felt that the passive approach allowed me to capture the gestures, body posture, and other non-verbal cues expressed during the interview.

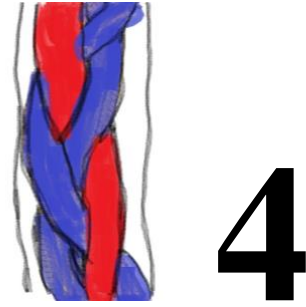
From this point, I followed the reflexive thematic analysis process of reviewing the themes against the dataset and beside the seven kaupapa Māori research principles that framed this research.

Kupu Whakarāpopoto (Summary)

This chapter began by discussing my core research questions and qualitative approach in section one. In section two, I examined kaupapa Māori theory and methodology and the seven kaupapa Māori principles that ground this research and provide its direction. Freire's theory of liberating the oppressed was also discussed as a synergy between his theories and kaupapa Māori.

The methods employed to collect the study data, such as the semi-structured research interviews and wānanga (workshops), were examined in section two. I addressed the challenges that arose in the gathering of data and examined the implications of the paucity of traditional knowledge on this kaupapa in subsequent chapters. Upon greater reflection, these methodological limitations allowed for other knowledge sources to rise to the surface and be explored, such as Māori art forms. The application of a mixed-method approach enabled me to obtain most of the data from an array of sources. This contributed to improving the scope of information required for the research and highlighted the challenges of undertaking kaupapa Māori research on historical topics. Section three highlighted how the data were coded and themed and how these themes were addressed in subsequent chapters.

The next chapter turns to another contextual discussion for my research and examines the historical context for my case study by exploring the Ngāi Tahu history of migration, wealth, and health alongside the many prominent legal statutes that eroded the strength of the iwi.



Hapūtanga / Māori in Maternity – Historical

Kai a Hawaiki, Ko Matiti, Matiti tua, Matiti aku,
Matiti aro...

Ko te Tīmatatanga (Introduction)

In this chapter, I aim to challenge readers to open their minds and hearts to, addressing health issues for Māori from the perspective of righting historical trauma. I am motivated by the comments of Māori lawyer, Te Tiriti o Waitangi specialist and orator Moana Jackson at the Indigenous Nurses Conference in 2017. He asserted that it was time to “prescribe change”. Māori health practitioners can lead this transformation by recognising the need for change, knowing one’s whakapapa and the history of colonisation. Jackson encouraged Māori health practitioners to be brave, to have courage and imagination. For them not to be discouraged by what others may think of advocacy for Māori, but instead be motivated by what their actions will do to improve the wellbeing of their descendants to come. He reminded me, as a Māori health practitioner and māmā, that if anyone can be brave, it is wāhine Māori. We have come from a long line of resilient tūpuna wāhine who traveled, navigated, and negotiated many different pathways. With this in mind, I feel I should also traverse sensitive professional boundaries to advocate for Māori in maternity and Māori knowledge inclusive of, and beyond the Tiriti o Waitangi principles (Kai Tiaki, 2017, p. 26).

Ngāi Tahu birthing traditions are taonga tuku iho no ngā tūpuna (treasures passed down from our ancestors). Like other Ngāi Tahu knowledge tendrils, birthing traditions have also suffered from a trauma that has stemmed from colonial superiority. In this chapter, the search for knowledge strands on customary birthing practices has extended broadly to capture data in different areas that make up the whole. I have addressed the people, the social environment, the defining legislation, the statistics, and the reclamation of Māori health through the establishment of Māori health initiatives. The first section of this chapter addresses the impact of the settler's arrival into the South Island on the health and wealth of Ngāi Tahu. This section also examines some of the critical land transactions and subsequent land alienation Ngāi Tahu endured, and the broken Crown promises that led to further hardship and compromised health for iwi members. The restrictions placed in land transactions by the government limited Ngāi Tahu's access to mahinga kai (food resources) which, in turn, contributed significantly to the eventual malnourishment of many Ngāi Tahu, both physically and spiritually.

The challenge for Ngāi Tahu was to achieve what Europeans considered an acceptable standard of sanitation in their homes and villages without feeling demoralised in the process. Recorded in Royal Commission reports on Ngāi Tahu wellbeing during this time, were comments from Ngāi Tahu members stating how difficult and overwhelming the transition off their land was, and the negative impact this had on their health (AJHR, 1881, 1885, 1891). Members of Ngāi Tahu were transported from a place of knowing themselves and their world, to a place of struggle and disbelief. This was a morbid and grueling time for Ngāi Tahu, yet it is essential to understand the context that enveloped those tribal members and fueled the decline of many Ngāi Tahu traditions (Anderson, 1990; Dow, 1995; Lange, 1999; Reid, 2017; Tau, 2003, 2017). This section also highlights government legislation that contributed to the suppression of traditional birthing knowledge, such as the controversial Tohunga Suppression Act in 1907, facilitated by Māori politicians, such as Āpirana Ngata, James Carol, and Maui Pomare.

The second section moves towards the concern for the high rate of infant mortality for both Māori and Pākehā that led to a stronger push by the government to utilise Western treatments and practices; this included the introduction of district health nurses to work amongst the communities. Other health initiatives that commenced at this time addressed Māori maternal and family health, included the encouragement of Māori to

undertake nursing training. This section also discusses the role of the native schools in terms of primary health assessment, health education, and dispensing of medications. Recognition is given to the first teachers who became the forerunners of what we know now in New Zealand as the Public Health Service. Public health nurses are now allocated to every early childhood, primary, and secondary school. These pioneer teachers became the eyes and ears of the Māori community. They were in the optimum position to provide health information and education when little else was available or accessible.

Section three provides a historical snapshot of significant Māori health and social initiatives from the 1920s that attempted to address the health inequalities between Māori and Pākehā. The early collaborative efforts that took place between government departments, marae, Māori politicians, and Māori medical practitioners to rectify this status are included. The Māori Councils established under the 1900 Māori Council Act enabled Māori at marae level to instigate health by-laws. These by-laws enforced improvements to living conditions and sanitation in Māori communities. This section also addresses the hospitalisation of birth and how influential the Obstetrical Society was in 1927; perpetuating the idea that birth was a surgical procedure requiring a clinical setting. Ironically, at this time, Māori midwives continued their midwifery work in the remote regions, including the Islands off New Zealand, such as Rakiura and Wharekauri. Here they delivered maternity care to whānau on horseback, on foot or via boat, until their services were dismissed by the introduction of new entities like the Māori Health Inspectors, Māori Sanitary Inspectors and Native Nurses (Dow, 1995, 1999; Bryder, 2003; Hutchings, Ngāti Porou, Te Whānau a Apanui; Murchie, 1990).

The concluding section within this chapter aims to highlight the attempts by Māori to have autonomy over their wellbeing including their maternity practices. Simultaneously, this section alludes to the challenges that confronted Māori politicians, Māori health practitioners and Māori communities in the 19th and early 20th century. They tried to maintain cultural practices, but the assimilation wave swept all in its wake, in what Europeans considered as best practice for all.

4.1 Section One: Influences on the health of Ngāi Tahu

Atholl Anderson (1998) wrote an ethnohistory on the southern Māori, AD 1650 to 1850, in which he discussed the various phases of Pākehā settlement in the South Island, and the sharing of skills and resources. His narratives spanned the commencement of the seal trade (the 1790s until 1827), then the flax trade (between 1813 and 1840) and, in between this, the Southern whaling period in 1829. Anderson's exploration of early writings by J.R. Kent (1823) and sealer John Boulton in 1827 and 1828, alongside old historical drawings, indicated that many Southern communities were thriving at this time.

With a nominal array of historical records depicting Ngāi Tahu village life, what has been accessed rests upon very few historical researchers and manuscripts. The snippets about domestic life were often scattered thinly amongst issues of concern relevant at that time. For instance, the arrival of settlers, the trade industry and land purchasing (Anderson, 1990; Anderson & Tau, 2008; AJHR, 1881, 1889; Beatties, 1916, 1994; Best, 1934; Wakefield, 1889; White, 1826). The literature revealed that villages were substantial, especially in the Foveaux Strait area, where tribal enemies were further afield. The frequent arrival of European vessels appeared to bring more opportunity than disease at this time.

Anderson's (1998) impression from his research suggests that, before the 1830s, there was no written evidence of epidemics in the South Island. This is in contrast to what was happening internationally at this time. The plague (bubonic, septicemic, and pneumonic) caused mass mortality in Europe and Asia from the mid 14th century through to the 19th century. Smallpox infected North America and Australia in the late 18th century. Spain struggled to contain yellow and dengue fever and measles, while cholera, malaria, tuberculosis, and influenza played their destructive parts in reducing the populations of the world during epidemics over periods of time (Lange, 2003; Oldstone, 2000).

The introduction of diseases via European contact with Indigenous populations around the globe has been catastrophic due to isolated Indigenous communities having minimal exposure to disease pathogens. Black's (1957) research highlighted that the smaller the

population is, the higher the mortality rate when impacted by an epidemic. The higher the mortality rate, the more significant the social disruption, when leaders and knowledgeable people die, leaving tribes in very compromised social states (Walker, Sattenspiel, & Hill, 2015).

Two powerful concepts in Māori life can be credited with the management of severe illnesses and iwi etiquette, namely: tapu and noa. These spiritual values provided effective disease controls that initially aided in reducing the spread of infectious and deadly diseases (Anderson, 1998; Beattie & Anderson, 1994). Tapu means to be set apart or sacred; while noa is the opposite, free from tapu restrictions or unimpeded, or something that can break the sacredness of a thing, place or person. For instance, the application of tapu over spaces and people placed them in a state of isolation. This had some bearing on reducing the risk of contamination by contagious diseases. The tapu and noa principles were such authoritative sources of justice and consequence that it policed the adherence to cultural practices and contributed to the physical and spiritual wellness of Māori. Compliance was achieved through the absolute belief that if tapu were violated, then something negative would follow for the person or group that made the infringement. The overwhelming sense of wrongdoing or impending doom would often send the perpetrator into a state of unwellness, both physically and spiritually (Buck, 1950; Mead, 2003; Moorfield, 2011). The reality of Māori domestic life also influenced their life course. As hunter-gatherers they worked hard to collect food and maintain their supplies during the leaner months. Hard work and tribal feuds maimed and tired these earlier ancestors, significantly reducing their average life expectancy.

Māori life expectancy and the health of Māori pre-colonisation

According to sociologist and leading demographer Ian Pool (1991), the average Māori life expectancy in the eighteenth century appeared to be approximately 30 years; this is a similar age to other global societies at this time. Augustus Earle came to New Zealand in 1827 and traveled to the Hokianga area. He described Māori as healthy and muscular, full of life and energy. Less than 13 years later, when politician Edward Wakefield

came to the Hokianga, his description of Māori provided a grave comparison. He noted the appearance of Māori as being miserable from illness, weak and emaciated, and a solemn contrast with the healthy bodies witnessed earlier by Earle (Wakefield, 1889).

Pool also noted that, in the early writings of historians, explorers, and whalers, there were no descriptions of a cancer-like illness. Medical historians thought, alongside heart diseases, cancer would not have been an issue for Māori due to their short lives. Degenerative conditions, like cancer, take years to develop and are more evident in older people (Earle, 1966). However, deadly diseases did come later. With minimal immunity to introduced viruses, many Māori succumbed, especially to the influenza, whooping cough and measles epidemics from 1834 onwards (Anderson, 1998, p.196; Lange, 1999, p. 32; Newman, 1881; Thomson, 1854, pp. 468–9). Influenza, known to Māori as *rewharewha*, created the greatest threat to the Māori population, alongside measles, which affected most *iwi* throughout the 1900s (Anderson, 1998).

Skin rashes, eye diseases such as conjunctivitis and ophthalmia, and tooth decay were noted in the Māori community throughout the country in the 19th century (Woon, 1839). Dental records highlighted that the reason for poor dental health for Māori was their fibrous diet of plants, meat, and seafood. These food sources caused a wearing down of their teeth, and infections were able to enter the body through the root canal, and this often led to blood sepsis and death if untreated (Woon, 1839).

Historian J.H.R. Owens (1972) researched the records of the Wesleyan Missionary Society dating back to 1823. Although Owens' research was predominantly concerned with the Wesleyan missionaries in the Hokianga region, their circumstances were likely to have been experienced in other areas where missionaries were situated. The Christian Missionary Society arrived in the Bay of Islands in 1814 with missionary Samuel Marsden and his assistants. The Wesleyan-Methodist society followed in 1823; initially into Northland then on to Hokianga in 1824 (Davidson & Lineham, 2015). Owens suggested that European disease affected the initial relationships the missionaries had with Māori. He explained that Māori associated illness with religion and the European God. Missionaries did seem to concur on the point that European diseases were best treated with Western medicines and an active missionary persuasion to accept the power of the European God.

Owens (1972) contended that, based on the writings of the missionaries, it was clear that missionaries lacked the medical knowledge to best deal with the poor health of the local Māori. There was evidence that the Wesleyan missionaries tried to get medically trained missionaries to come to assist them with health issues in the Māori communities, but this did not occur. Instead, missionaries were supplied with medicine chests and medical provisions to distribute to those in need. The restocking of these supplies was sporadic and often unreliable, leaving both the missionaries and Māori to fend for themselves (Owens, 1972; Woon, 1839).

Owens (1972) agreed with the writings of Ernest Dieffenbach in 1843 and S. Martin in 1845, who praised the missionaries for being innovators of change by teaching Māori to read and write te reo Māori and English. However, Owens also criticised the missionaries for what he believed was their neglect to teach Māori about health and wellbeing. This neglect included knowledge of introduced diseases and the integration of new technologies and domestic practices, such as how to wash and dry European clothes and blankets correctly. This would ensure the clothes were not worn damp, further exposing Māori to potential illness (Dieffenbach, 1843; Martins, 1845). It was not long, however, before the government instigated the building of hospitals in the 1840s (Marsden, 1932; Stock, 1899; Williams, 1867). Doctors became native medical officers and were subsidised by the government to deliver medical care for Māori who could not afford medical treatment (Marsden, 1932; Stock, 1899; Williams, 1867).

In terms of midwifery, it was reported in the missionary records that, before 1840, Māori appeared to be faring better than European women at managing their pregnancies, including experiencing lower rates of maternal and infant mortality. Owens (1972) stated that he could find no evidence in the Wesleyan records of Europeans approaching Māori for childbirth advice or implementation of Māori cultural practices to improve the Pākehā infant mortality figures. With the settler population becoming more prominent in New Zealand at this time, so began a blending of cultures with more mixed relationships occurring in the South Island. This led to an accelerated assimilation process for South Island iwi more so than their Northern counterparts; also leading to a growing number of children with Māori and Pākehā ancestry.

According to Anderson (1991), the early European arrivals from 1780 were young, single men, predominantly English, followed by Scots, Irish, Australian, and American sealers. The first 'half-caste' (mixed Māori and European heritage) children were noted in the writings of traveler and sealer John Boulton after his arrival at Port Jackson in the Coromandel in 1826. Boulton said that he saw 'half-caste' offspring in the 1820s. The term 'half-caste' denoting someone who has Māori and European parents was a contentious description when it was given in the 19th century by Pākehā, as it is today. References to Māori who were 'half-caste' were often stigmatised with a sense of inferiority, being impure or of a lesser breeding that needed to be concealed. The potential for an inferiority complex was real for some who felt that "half-caste" defined the percentage of Māori they were or were not. Paterson (2010) asserted that New Zealand was founded on the coloniser dividing the colonised. He iterated that terms such as, 'race' or 'half-caste' held the divisions between the majority and the minority, among those who held power and those who did not. Therefore, the term 'half-caste' became associated with a derogatory disposition rather than an uplifting definition for many. Over time, this has led to people feeling more empowered to self-identify their ethnicity (Pool, 1991).

Many others were born in the 1830s and 1840s as the whaling industry grew, and more men were available to partner Māori women. Scots between 1848 and 1860 dominated the second wave of men to arrive in the Otago area. A European settlement of boat builders in Port Pegasus (Stewart Island) during the 1820s saw many European males marry southern wāhine Māori. Their offspring contributed to the growth of a blended ethnic community in that region (p. 3). The 1886 census highlighted this reality in the South Island, with prominent populations in the Otago and Southland areas, in comparison with the North Island (Pool, 1977; Anderson, 1991, p.17).

Pool (1977) states that there was a higher number of Māori women living with Pākehā males in the South Island than in the North. South Island wāhine Māori who partnered with Pākehā tended to move away from the pā to live with their Pākehā husbands. In the North, however, Pākehā males would live at the pā with their Māori wives. The children of these Northern Māori and Pākehā unions also remained in the Māori villages and identified as Māori. Consequently, North Island Māori seemed to have retain their language and cultural practices, while South Island Māori were quick to assimilate to

the settler culture (Anderson, 1991, p. 31). Ngāi Tahu marriages to Pākehā and their movement away from the home pā is a likely reason for some of the loss of maternity knowledge and tikanga. Notably, when Ngāi Tahu wāhine adopted the practices of their husband's culture, this was inclusive of how they began to manage their pregnancies and births.

When it came to collecting census data of those who identified as Māori, Pool argued that Southern offspring from the earlier mixed-raced families were drawn more towards their European ancestry than their Māori whakapapa. Although Pool acknowledged that there were small clusters of Māori villages that did manage to retain many of their tribal practices, these villages were by far in the minority (Anderson, 1991). It was written and vocalised by many settlers and politicians at this time that Māori were a dying race. Atholl Anderson (1991) believed this was not because of the fatal diseases that ravished Māori, but due to the coming together of two cultures and the blending of races that naturally took place. The numbers of “full-blooded” Māori reduced and led to the notion that Māori were in a rapid and non-reversible decline (p. 17). This was likely to have had an impact on the real Ngāi Tahu population figures at this time. Still, the crippling land purchases were drastically compromising the wellbeing of Ngāi Tahu. They continued to play “catch up” with their health in all aspects of their cultural lives.

Land Transactions

Many Crown inquiries took place following the signing of Te Tiriti o Waitangi (Treaty of Waitangi), including one by Thomas Smith and Francis Nairn in 1879. Smith and Nairn were asked to make inquiries about the purchase of the Ngāi Tahu block of land in 1848 and 1849 by land Commissioners Henry Kemp and Walter Mantell. Governor Grey instructed Kemp and Mantell to purchase land for the new settlers coming to the South Island. Other blocks of land in Akaroa, Ōtākou and Murihiku were also sold to meet the settler demand, and these land transactions came under contention between land agents and Ngāi Tahu (The Ngāi Tahu Report, Tau, & the Ngāi Tahu Māori Trust Board, 1991; Anderson, 1991).

Otago historian Bill Dacker (1996) said that the New Zealand Company bought the Ōtākou land block purchase under the New Edinburgh scheme, which was driven by the Free Church of Scotland, a Scottish denomination that broke away from the Church of Scotland in 1843. The target of the scheme was to establish a church-based community in Ōtākou. Twenty-five chiefs signed the sale deed of 400,000 acres with the New Zealand Company. They did so under the provision that a tenth of the land sold would be put aside for the tribal welfare of Ngāi Tahu. The supposed influx of immigrants took their time to arrive; four years after the purchase of the land, the settlers disembarked from the boat on the soils of Ōtākou in 1848. Even with the arrival of the “New Edinburgh” settlers, Ngāi Tahu still waited for the promised tenths to be allotted to them but to no avail. No one did the surveying for the tenths, and there were no discussions to ensure the tenths were allocated, leaving Ngāi Tahu with no land or income and a bleak future ahead of them (Dacker, 1994, p. 19).

In Canterbury, Kemp was on the HM Sloop Fly in Akaroa Harbour in 1848 with another group of Ngāi Tahu chiefs, signing the most prominent land purchase in the Ngāi Tahu territory. Kemp arranged a sale of 13,551,400 acres for a mere 2000 pounds. This devastating transaction became known as “Kemp's Deed”. The concept that Ngāi Tahu were persuaded to “sell” the land for a pittance remains a difficult concept to fathom. However, the fundamental reasons for Ngāi Tahu engagement with Crown officials over land were for potential economic growth through new opportunities, more trade, and new technologies (Department of Justice, 1989; Tau & Ngāi Tahu Trust Board, 1991). Throughout the 19th century, Ngāi Tahu were eager to attract more immigrants into their communities. They saw the addition of more settlers as beneficial for economic development, business knowledge, and growth. They did not feel threatened by the immigrant population at this time. It was, in their eyes, a win-win situation that would advance to prosperity and development for all (Tau & Ngāi Tahu Trust Board, 1991; Waitangi Tribunal, 1991).

Before the signing of Te Tiriti o Waitangi, Ngāi Tahu were already in the trade business and holding their own financially in many of the ports in the Canterbury and Southland regions. They believed that opening up the land would further enhance their tribal economy with growth in trade. The boost to the local population was likely to have been viewed as an exciting collaboration that would take Ngāi Tahu into a wealthy

phase of their economic development. Regretfully, Ngāi Tahu could not foresee just how potent and destructive their naivety would be. A vision of economic growth turned quickly into debt, as well as the most protracted battle of Ngāi Tahu fighting for their rights in unfair land transactions, unfulfilled promises from land sales and Te Tiriti o Waitangi breaches (Anderson et al., 1998, 2014; Mackay, 1891; Dacker, 1994, p. 20).

Many Ngāi Tahu suffered hardship after their trading became smothered by the devaluation of prior trade goods. Potato, and other introduced vegetables, replaced the kūmara. Pounamu struggled to retain value over metal and the growing interest in European merchandise. By 1850, the limited land acreage and access to mahinga kai highlighted the inability to produce quantities of tradeable produce that would permit Ngāi Tahu to compete against the rising numbers of European settlers (Mackay, 1871, 1891).

Writer and researcher of New Zealand history books Vincent O'Malley (2016) highlighted that Māori not only lost land, but they were also deprived of “political authority”, which took away Māori autonomy over the land set aside as reserves. Māori did retain some rights over land whilst under the “native title” as guaranteed under Te Tiriti o Waitangi. However, once the land had been sold, it then became a “Crown title”, which gave the authority to the Crown (p. 46).

By 1863, the Crown had possession of 99 percent of Ngāi Tahu land. It only took 23 years post the signing of the Tiriti o Waitangi, and only 13 transactions, for Ngāi Tahu to be disenfranchised from three-quarters of the South Island. It was disclosed eventually in 1998 by the Crown, that the land purchases were indeed a treacherous breach of the Tiriti o Waitangi principles (Evison, 1987; Ministry of Justice, 1998, p. 42).

The government priority of Māori health before the 1900s was largely non-existent; the focus appeared instead to be on land transactions and politics. Social and health issues appeared to be much lower on the government's priority list due to the common assumption amongst many theorists, historians, medical experts, and politicians that the Māori race would become extinct within a short period of time; the attention or resources spent on Māori would soon no longer require any consideration (Evison, 1987; Mackay, 1871, 1891).

The Native Department did administer a Civil List Fund specifically for health and social issues. The English statistician, also known as the famous “Lady of the Lamp”, Florence Nightingale, recommended immediate redress of housing and more attention to improving the diets of Māori in her government report in the 1860s. The government did not respond or provide resources from the Civil List fund towards Nightingale’s recommendations; however, she continued to have a significant impact on New Zealand health with her insightful health reports to the New Zealand government, and input in the nursing philosophy used in the development of nursing training.

Nightingale’s legacy for Māori wellbeing

Florence Nightingale (1979) raised the profile of nurses after her innovative stint nursing in Scutari during the Crimean War (1854 -1856). She was based in a British makeshift hospital with no resources and appalling conditions, with soldiers lying in shocking states throughout the halls. Nightingale worked hard and methodically to integrate systems, logistics, sanitation schemes with unstinting compassion for her staff and the wounded. Post Crimea, she returned as a humble hero to Britain. She was rewarded with money from the British Government, which she promptly put into establishing the St Thomas’ hospitals and the Nightingale Training School for nurses. Nightingale became an advocate and authoritarian on healthcare reform, publishing *Notes on Hospitals* in 1859 that gave precise details and instructions on how to run civilian hospitals. She also wrote on public sanitation issues in India for military and civilian hospitals.

The Australian and New Zealand Governments wrote to Nightingale, requesting Nightingale-trained nurses migrate to improve the standard of care being delivered in the local hospitals (McDonald, 2004; Keith, 1987). Governor Grey (1860) wrote personal letters in 1860 to Nightingale, asking specifically for her opinion on how to better care for the “natives” within the schooling and hospital settings in New Zealand. At the end of his letter dated 13th April 1860, he requested her guidance, believing that

Nightingale's reputation as the peoples' advocate might shed some light on how to improve the health issues in Aotearoa.

Florence Nightingale dutifully responded to Grey with an inquiry, that she later titled *Note on the New Zealand Depopulation*, and a second paper, titled *Notes on Causes of Deterioration of Race*. Nightingale wrote these papers from the information she requested from New Zealand medical experts. She commented that she never felt she had enough data from New Zealand, and it made writing these papers problematic. However, the information that Nightingale did glean told her a lot about the lack of prior focus on the wellbeing of Māori, a message that she was able to convey to the Crown (Grey, 1860; Sinclair, 1987; McDonald, 2004; Nightingale, 1979). Nightingale argued that "natives" could not be educated like "civilized" children. She said it would be detrimental to their wellbeing and would lead to death. Nightingale suggested more space within the native schools, proper ventilation, cheerfulness, and more outdoor work and play. She also said that education for native children must be relatable to them and include their history. She acknowledges that the objective was still to civilize the children but to do so slowly and in a way that is congruent to the natives as a people (McDonald, 2004, p.185; Nightingale, 1979).

Nightingale also stressed that identity and their social determinants of wellbeing were important to Māori in terms of care and treatment. She said the top six Māori health concerns were: fever, chest, bowel and skin disease, scrofula (glandular swelling often associated with tuberculosis) and rheumatism. She recommended that improvements to dwellings and exercise would aid fever and chest disease; bowel and skin disease would be reduced if diet and better personal habits were addressed; scrofula and rheumatism would be less if they had better accommodation and clothing. Nightingale also argued it was essential to improve the ventilation and sanitation in the schoolhouses and to encourage physical education for the native children (McDonald, 2004; Nightingale, 1860, 1979).

Untrained women initially nursed in the first hospital in Wellington in 1847 and subsequent others in Dunedin (1851) and Christchurch (1862). It was only in 1883 that Nightingale's earlier ideas of training nursing staff and improving hospital cleanliness came to fruition. The first nursing lectures took place in 1888 with the addition of a nursing exam 12 months later. Nightingale's influence from her nursing experiences in

the Crimean War in 1854 exposed her advanced nursing approach. It influenced many other countries, including New Zealand, to adopt the Nightingale nursing practice. This included heeding her advice on investing time in research and gathering data to provide evidence for improved care. The development of hospitals in New Zealand and the training of health practitioners under Western biomedical models raised another set of challenges in terms of equitable provision of health care and access to necessary health services for Ngāi Tahu (Keith, 1987).

The introduction of hospital care for Māori

In 1840, Doctor John Fitzgerald drove the campaign to provide hospital care for Māori and immigrants who could not afford private medical services. Four state hospitals (in Auckland, Wellington, Wanganui, and New Plymouth) were established in 1846 (McKillop, 1998). Over the next few decades, health care became regionalised, and their funding and management divided between the districts. Health services for Māori and Pākehā became separated, and according to McKillop (1998), unequal. In the 1860s, a flurry of hospitals were built; not to meet the needs of Māori but to attend to mining accidents during the gold rush years in New Zealand history. These hospitals were located near mining villages that could perform surgeries immediately on severe injuries from mining accidents (Bryder, 2001; Dow, 1995; McKillop, 1998).

Meanwhile, accessing medical services and treatment for Māori continued to be challenging. The colonial government did not provide any further advances for Māori when they passed the Hospital Act in 1885, which legislated the development of Health Boards and the geographical boundaries of the Health Districts. From 1885, the Public Hospital System came into being, and the Charitable Aid Trust facilitated the establishment of these hospitals (Bryder, 2001; Butler, 1886; Maclean, 1932). By this time, there were 38 hospitals around New Zealand, all of them still located a long way away from Māori settlements. Government officials argued that this was due to the increase in settler numbers and the better economic capacity of settlers that allowed them to apply for subsidies from the colonial government to build hospitals. The earlier hospitals in New Zealand were scant in their offerings of care, often a single bed and

limited staff. In addition to this, fees created barriers for Māori to attend and the medical jargon employed generated, for some, a fear of Western treatments (Beaties, 1990; Bryder, 2001; Carroll, 1903, p. 4; Maclean, 1932; Dow, 1999; Lange, 1999).

It was also thought that Māori were discouraged by hospital administrators from attending the pioneer hospitals because they were not 'entitled to access' due to not paying rates (Bryder, 2001; Dow, 2001). This sense of not being eligible to hospital services also applied to Ngāi Tahu throughout the South Island. Land purchases by the Crown did include provisions for schools and hospitals, yet, under provincial governments Māori were not paying rates and, therefore, this agreement for public services was not honoured (Bryder, 2001; Dow, 2001; Maclean, 1932).

Mr William Fox, the Colonial Secretary and previous New Company land agent, made attempts to improve the situation for Southern Māori when he presented a memo to the House of the General Assembly in 1866, addressing the extinction of the Southern Province land titles (Fox, 1866). Fox argued that the Crown had not paid its arrears to Māori in the Otago and Canterbury provinces and that they should have been paid out a generation before. Fox felt that Māori had been neglected and deserved a payout that adequately reflected their loss (Fox, 1866). Fox's plea was not accepted, even though the Ngāi Tahu land purchase agreements promised schools and hospitals, along with an assurance that the general wellbeing of Ngāi Tahu would be addressed. Ngāi Tahu believed these promises would be initiated upon the sale of their land, but this was not how the Native Land Commissioners saw it. Smith and Nairn (1881) came up with a solution, requesting that the government begin the process of retribution and address the situation for those who received inadequate reserves or were left landless due to having no access to the small acreage of allocated reserves.

Māori Parliament

Māori politics stirred due to the lack of action the government was taking to rectify Māori grievances. The inception of a Māori Parliament took place with the desire of Māori governorship and stronger front to put a halt to the selling of Māori land. Kotahitanga (unity) was the name of the pan-tribal parliament established in 1892. This movement was never formally acknowledged by the New Zealand government, even with over 30,000 Māori signing allegiance to Kotahitanga at the time. It was an influential group. It paralleled the Kingitanga movement in Waikato, and discussions were held about the possibility of joining the two movements. This collaboration did not eventuate, due to the Kingitanga movement being specifically for the Waikato iwi and the Kotahitanga being pan-tribal (Lange, 1999; O'Regan, 1993).

Notable tribal representatives from around the country met at Papawai in the Wairarapa to conduct business as a Māori Parliament until 1902. My great-grandfather, Teone Tikao, was the Ngāi Tahu representative at the Kotahitanga assembly at Waipatu in Hawkes Bay in 1892. Tikao became the Chairperson of the Kotahitanga Great Council in 1893 and, at times, held the role of Speaker. He attended assemblies at Papawai in the Wairarapa and many whānaunga (relatives) of Tikao remembered hearing of his trips to the North Island to attend meetings (Lange, 1999; O'Regan, 1993, n.p). Kotahitanga did not achieve their original intention of being self-governing.

However, Kotahitanga did influence the passing of the Māori Land Administration Act of 1900. This legislation secured blocks of land for Māori papakainga. They also achieved the Māori Councils Act 1900, which allowed for Māori councils and local Marae committees to be elected as self-governing bodies. Māori councils were authorised to control the health and welfare of Māori. This authority meant prescribing rules in the form of bylaws in their council boundaries, with committees formed beneath the councils enforcing these bylaws (Hill, 2004). Hill (2004) alluded in his writing to the government supporting the Māori Council Act as a strategy to make Kotahitanga defunct. At a meeting in Waioomatatini, Gisbourne, in 1902 with Kotahitanga and the Māori Council in attendance, it was decided to merge Kotahitanga with the Māori Councils, leading to the disbanding of Kotahitanga as a separate entity (Hill, 2004). An

early focus for the Māori Council members was to educate Māori communities on the importance of proper sanitation systems and assisting Māori to make improvements for better health outcomes.

Sanitation

An imposing factor that led to poor sanitation and increased risk of infection, was the shift post -1840 from predominantly hilltop kainga that allowed effluent to be drained away from core living areas, to living in dwellings in low-lying areas with minimal drainage (Lange, 1999; Mackay, 1891).

Numerous government reports from Royal Commission inquiries (such as the 1879 Smith-Nairn Royal Commission; then *Middle Island Native Claims* in 1886 by Commissioner Mackay; in 1906, the *South Island Landless Natives Act*; and in 1921 the *Native Land Claims Commission*) concluded that Ngāi Tahu were unfairly treated through dubious land purchases and unfulfilled promises from the Crown regarding land, education and health services. The Crown dealt another disempowering blow when they allocated land that was not viable to Ngāi Tahu as reserves. The soil conditions were poor, access to the property difficult, they did not have enough acreage to create an economic unit, and there was an overall unfamiliarity with how to work with the allocated reserves. These challenges contributed to many whānau Māori at that time suffering from deprivation that led to ill health (Lange, 1999; Mackay, 1891).

While some were concerned about the inferior land options allotted to Māori, the Native Medical officers often wrote in their reports of their concern for the compromised ventilation in Māori dwellings. Robert Bedford, the Native Medical Officer in the Kaikoura area, said in 1885 that he was troubled about ventilation in the small huts situated in the Māori villages. He stated that, because the air had minimal diffusion in and out of the huts, along with the use of domestic fires, there was a risk of circulating impurities that could cause lung infections (Dow, 1999). Also, Bedford believed the humidity in the huts and the dampness of the clay floors exacerbated the risk of respiratory diseases (AJHR, 1885, G.-2a, p. 12; AJHR, 1903, G1, p. 1; AJHR, 1908,

H:31, p. 133). However, it was noted that the sanitary conditions throughout New Zealand at this time and earlier were grave. Nursing matrons and doctors stationed around the regions appealed to the government in their reports to address cleanliness and sanitation.

The 1864 Dunedin Sanitary Commission report stated that the illnesses that were afflicting large numbers of people in cities and rural areas were preventable, and they asserted there was a widespread apparent lack of effort to address this (Dow, 1995). Howden-Chapman (2004) explains the miasma theory in relation to housing in the 19th century, which was occupied by a more significant number of people, not constructed for the conditions, and often had inadequate ventilation. The concern was that redolent air in these houses held airborne diseases such as malaria. Therefore, public health initiatives at this time needed to focus on housing improvements inclusive of optimum ventilation to reduce airborne diseases. The miasma theory removes the blame from the people, such as Māori, and places it on the condition of the houses and their location (Howden-Chapman, 2004).

Interestingly, a doctor William Fyffe, in his role as the Sanitary Commissioner, reported in 1900 that many Pākehā could learn from the hygienic practices of Māori (Dow, 1995). A.W. Thompson, a Native Department Health Inspector, also commented in 1891 in his census report to the Houses of the General Assembly that he felt that sleeping on the bare ground caused Māori to catch colds, which led to consumption and death. He thought that this had become so ingrained in Māori sleeping habits that the observed decrease in Māori in the Oamaru area was only going to get worse until the local Māori changed their sleeping behaviour (AJHR, 1885, G – 2a, p. 13). Water supply to these villages, according to Bedford, was reliant on the creeks in the area. During the warmer seasons, the water levels were significantly reduced, providing less water for domestic chores, while animals were drawing off the same source. Bedford believed that these circumstances increased the risk of water contamination (AJHR, 1885, G – 2a, p. 13).

Doctor John Drysdale, the Native Medical Officer for Port Chalmers in Otago, felt that the natives in Ōtākou had been for some years “fair” with no epidemic inflictions. However, Drysdale did note the “dying out” of full-blooded Māori was primarily in his opinion due to rheumatism, chest complaints and skin diseases (scabies) as Māori paid

no regard to the sanitary laws (AJHR, 1885, G-2a, p. 14). Reports from the Chief Health Officers continued to update the government on the state of sanitation in Māori villages throughout the country and the efforts in place to improve the existing situation. The provision of education by the members of the Māori Council and Native Health Inspectors during their regular inspections improved housing constructs and conditions and led to better water drainage systems. Coupled with this, the drive by the Māori Council to get more trained Māori nurses in amongst their people provided, as W. Bird described, “preachers of the gospel of health”. These nurses were trained to attend to many cares but primarily to be the “sanitary reformer” of every village. It was felt that, once this serious issue was dealt with effectively, progress into better health for Māori would be seen (AJHR, 1910, E3, p. 7; 1908, H31; 1903, G1, p. 1; 1903, H31, p. 57). The hard work was being put in place, yet the Crown promises over land reserves were not being honoured and continued to harm the health and wealth of Ngāi Tahu.

Broken promises

In 1887, Alexander Mackay, Native Commissioner for Nelson, reemphasised to the Native Minister that in the 1860s Ngāi Tahu were indeed offered schools and hospitals as compensation to the broken promises over land sales in the 1840s and 1850s. These offerings of education and health were not to be provided when the European communities deemed them necessary but rather when Māori needed them (Mackay, 1887; Dow, 1999).

Mackay noted, in the 1891 Native Claims Report, that ten years previously, Sir George Grey had also said that the intention was to give Ngāi Tahu “considerable reserves”. The impression Mackay had, was that the original plan had never been adequately carried out (AJHR, G-7, Session 11, 1891, p. 3). Grey stated he was not aware that the concept for reserve allocation was arranged through the tenths scheme. Grey believed that the reserve size would be more significant than 14 acres per person. Therefore, this provided Mackay with the evidence to say that the government orders were not delivered, and the terms of the Kemp deed drew considerable discord (AJHR, G-7, Session 11, 1891).

Mackay calculated that approximately 20 acres were needed for “subsistence existence”; therefore, 50 acres would be the right amount of land per person to allow for economic opportunities and wellbeing. However, what Mackay discovered under the Kemp Deed was that only 9.1 percent of the Ngāi Tahu population had 50 acres of land, 43 percent had less, and 47.7 percent had no land (Dacker, 1996, p. 72; Tau, 2012).

Ngāi Tahu elder Hoani Matiu surmised, in his response to the 1891 Commission Inquiry at Waikouaiti in Ōtākou, that he was tired of the numerous investigations into the condition of the Ngāi Tahu people. Hoani Matiu expressed that they had established a fund to assist Ngāi Tahu leader H.K. Taiaroa to take their grievance claims to the Crown. Matiu recalled that another commission took place in 1887, but nothing had come out of any of these inquiries, except contempt and frustration for Ngāi Tahu. He questioned why the government continued to postpone claim settlements yet continued to send commissioners to write reports and recommendations about the state of Ngāi Tahu. These reports seem to always fall upon deaf ears. Even though every commissioner came to the same conclusion; that land alienation and the Tiriti o Waitangi grievances inflicted upon Ngāi Tahu were valid. Yet no government action had taken place to rectify the situation for Ngāi Tahu. Many quotes in the reports from Ngāi Tahu representatives were directed at the conducting commissioner and Crown. Ngāi Tahu repetively questioned the legitimacy of the Crown inquiries. Ngāi Tahu representatives criticised the Crown for only coming to see if they had survived the hardship placed upon them by the settler government, the resulting illness and the economic adversity. Ngāi Tahu asserted loud and clear that the inquiries were only devices to gauge how long it would be before Māori perished, succumbing to their impoverished state and their inability to revivify (Mackay, AJHR, 1888, G:01,1891, Matiu, AJHR,1891, G7, p. 36; Smith and Nairn, 1880, G:06).

Ngāi Tahu iwi members H.K. and Tini Kerei Taiaroa commented on the lack of medical assistance in Moeraki. They reported that medical bills, including paying for doctors’ home visits or having to go to doctors located outside of their villages, such as in Oamaru or Dunedin, were adding to their financial burden (AJHR, 1891, G7, p. 46). Henare Te Maire was the clerk of Ngāi Tahu leader and authoritarian on Ngāi Tahu traditions, Matiaha Tiramorehu of Ngāi Tūāhuriri. From 1848, Te Maire wrote many letters in reflection of conversations he had with Tiramorehu and other tribal elders.

These letters were over the discontent of the elders regarding the litigious land sale to Kemp that year. Ngāi Tahu lost access to their mahinga kai (food resources) and the cost to seek recognition from the government was beyond what they earned or owned. The spillover of stress and deprivation equated to poor health, and, ironically, still having to voice their grievance over inadequate health care while often unwell themselves (AJHR, G7, Sess 11, 1891).

Nine members were elected to the joint committee to report on the South Island Māori land claims and seek information from people, papers, and records and then deliver their findings in a report to the government. The 1889 report was titled *Middle Island Native Claims Report*. Within this report, the members of the committee confirmed that no separate hospitals had been created for Māori and that the government decided that Ngāi Tahu could access the public hospitals, as these were “open to Natives equally with Europeans”. Most South Island hospitals reported that only small numbers of Ngāi Tahu patients were seen, which may be indicative of both of how uncomfortable Māori likely felt in these clinical institutions and the sporadic location of these hospitals, which were uncondusive to Ngāi Tahu attendance (AJHR, 1889, I-10, p. 2).

Ex-students of Te Aute College, such as Reweti Kohere, Timutimu Tawhia, and Maui Pomare, conducted health tours in the North Island around the Hawkes Bay area in 1889, promoting Māori health. These tours were the kakano (seed) for Māori health promotion and advocacy by Māori for Māori. Āpirana Ngata joined a tour in 1891 to the Ngāti Porou tribes and, as they went, they gathered more interest from Te Aute students, present and past, and that of the villages they visited. Ngata realised that the job of Māori health improvement was more significant and harder than he first realized, requiring more strategies to make any impact on Māori health (Butterworth, 1969; Lange, 1999). Te Aute College students under the Te Aute College Students Association, past and present, were invited to a conference in 1896 to discuss Māori issues not dissimilar to those raised on the health tours. These conferences became an institution of knowledge and progressive ideas aimed at improving Māori life (AJHR, 1891; Butterworth, 1969; Lange, 1999).

Over time, the Te Aute College Students Association referred to themselves as the Young Māori Party, a name that eventually became synonymous in 1909 with young Māori politicians in Parliament. Infant mortality and infant care featured in many of the

Te Aute Association conferences between 1897 and 1910. One of the most prominent members of the Young Māori Party, Āpirana Ngata, completed his Bachelor of Arts at Canterbury University in 1893. He wrote a paper while at Canterbury, which impressed Ngāi Tahu members at that time. Ngata emphasised his desire to improve Māori socially and morally through education and the eradication of what he believed were “harmful Māori customs” concerning the tohunga (Māori spiritual leaders). Ngata said some Māori were not authentic tohunga, but self-designated, and were delivering practices that were detrimental to Māori health and wellbeing (Cox, 1993; King, 1997; Ngata & Hiroa, 1986; Lange, 1999, p. 99; Tizard et al., 2006). Ngata’s assertions contributed to the debate on poor Māori health and led to the Tohunga Suppression Act in 1907 (more detail on this Act in the section to follow).

Another prominent Māori spokesperson at this time, was Dr Maui Pomare. His term as a Native Health Officer saw the instigation of the 1900 Māori Councils Act by the Māori Parliament (Paremata Māori), who were themselves established in 1892 to forge a stronger pathway and voice for Māori within the government (Beatties, 1990; Durie, 1998; Harris, 2004; Lange, 1999). The Māori Councils Act facilitated the establishment of 19 local Māori Councils and Marae Committees in most Māori districts. Most of the members of the Māori Councils were highly regarded within their hapū and iwi and were appointed to official government roles, such as native sanitary inspectors, to assist the work of the Councils. The purpose of the Councils, as outlined in the Act, was to oversee and make improvements to Māori communities with a strong emphasis on community health and welfare; focusing on sanitation and the registration of births (Beatties, 1990; Durie, 1998; Harris, 2004; Lange, 1999; 64 Vict, 1900, No 48, NZLII).

Premier Richard Seddon in 1902 agreed with Pomare that the Māori Councils were doing a great job at promoting health, assessing the health situation and census data, and disease prevention within their tribal areas. However, over time, the Māori Council members felt they were drifting away from their original intent of Māori autonomy. The Māori Council members were finding it harder to introduce Māori-policies and, instead, they were becoming vehicles to only deliver government initiatives (Callinicos, 1989; Cody, 1953; Durie, 1998; McKillop, 1998).

The Public Health Act in 1900 addressed sanitation to prevent the spread of infectious disease; ordered local authorities to build hospitals and provide medicines and

disinfectants to the poor; and to address the removal of the dead to a mortuary. The Act also required local authorities to address the sanitation of native settlements. This allowed the Governor to declare that a native settlement was a special district and therefore required a health committee to deliver on the requirements of the Public Health Act. The establishment of the Department of Public Health Department were directed to prioritise Māori health needs and concerns as a central government responsibility. This job was given to the Native Health Officer, Dr Maui Pomare (Cody, 1953; Public Health Act, 64 Victoria, 1900, No 25, NZLII).

Dr Maui Pomare was the first Māori doctor who graduated with a medical degree from Chicago Medical Missionary College in 1899 (Lange, 1999). He quickly climbed the hierarchy of health directorship upon his return to New Zealand. He became a Native Health Officer, which took him by foot to many Māori reserves and pā (Māori settlements) around the North Island, inspecting their water supplies, rubbish disposal, and sanitation. He educated Māori on how to improve their living arrangements to achieve better health. Pomare informed the government on what was needed to support Māori to live in healthier environments. Pomare ordered derelict houses to be burnt down to reduce rats and other vermin (AJHR, H-31, 1906, p. 67; Cody, 1953; Durie, 2000; Lange, 1999; King, 1992).

Pomare stated, in his official report on Māori Health as the Māori Medical Officer in 1906, that the decline in the Māori population was related to inadequate housing, poor access to food, inappropriate clothing for the conditions, unventilated houses and overall unhealthy pā. He said these were not, however, the cause of the most profound drop in numbers. Pomare attributed the arrival of Pākehā to Aotearoa and the assimilation process that followed as the primary cause of death for Māori, more so than a disease. He felt that Māori had become lost in the colonial takeover (Pomare, 1906; Raeburn, 1999, p. 20).

In 1911, Dr Maui Pomare vacated his Native Health Officer role to enter politics. A year later, Pomare was a member of the Executive Council representing Māori health. Pomare, alongside the Young Māori Party, with prominent members such as Te Rangi Hīroa Buck, Āpirana Ngata, Paraire Tomoana and James Carroll, continued to push for the welfare and health of Māori. They struggled to gain government support to improve

medical aid to Māori; not discouraged by this, Pomare raised his hand to become the Minister of Health in 1923 (Cody, 1953; Dow, 1995; Sorrenson, 1986).

Although Pomare was a government representative, in later years, his great-granddaughter, Miria Pomare, defended Pomare's work as she felt that he was often misunderstood as being under the thumb of the government and that his roots in Te Ao Māori had diminished. Miria Pomare argued that her great-grandfather was a dedicated advocate who fought hard to reduce disease in the Māori population by removing what he believed were carriers of disease and barriers to appropriate treatments. Pomare was among the group of Māori politicians who facilitated the passing of the Tohunga Suppression Act in 1907 (AJHR, H-31, 1906, p. 68; Best, 2001; Cody, 1953). He agreed that many tohunga were tika (right) and faithful in their role as tribal specialists in many fields, including customary birthing practices. Their role was to carry ancient knowledge of tikanga and kawa. Still, with the coming of the settlers and the traumatic changes taking place within Te Ao Māori, Pomare witnessed what he described as charlatan tohunga. These tohunga took people's money, tricking them into believing they could heal their illnesses, but in reality, Pomare believed this was not the case, and as a consequence Māori were dying unnecessarily (AJHR, H-31, 1906, p. 68; Best, 2001; Cody, 1953).

Tohunga Suppression Act 1907

In 1903, James Carroll, the Native Minister, also argued that the government needed to take a firmer legislative approach to ensure Māori were not led in the wrong direction by what he referred to as the “curse of their race”. Carroll stressed that “these people parading as tohunga do incalculable harm and I respectfully urge that more stringent steps be taken to put down this serious evil” (AJHR 1903, G-1, p. 1).

A report by James Carroll in 1903, presented in the House of Representatives on behalf of the delegates, called for by-laws that restricted the ability of tohunga to practice. These bylaws stipulated that tohunga should procure a license before practicing, they should not be permitted to utilise water for ceremonies, as had previously been done, nor were they to charge people for their services. They were also not allowed to discourage or stop Māori from attending qualified medical practitioners. Nor could they discourage Māori from having European medicines and, if they did, a penalty would be imposed by the Māori Council (AJHR, 1903, G-1, p. 6; NZLII, 64 Vict, 1900, No. 48). Āpirana Ngata was criticised by his Pākehā colleagues when he raised the above suggestion to license tohunga, Ngata rebutted to the comments by saying:

I was told that by issuing licenses, I was indirectly supporting tohungaism. However, the object of having regulation empowering licenses was this: we practically rendered tohungaism illegal except it was conducted under the control of the Council (Ngata, 1907; NZPD, 119, p. 521).

James Carroll reminded the critics that, due to the excellent work of the Māori councils, Māori housing conditions had vastly improved. The old whare were replaced with wooden ones, water supply and quality had been developed by fencing out animals. The Māori Councils had implemented stronger supervision of the alcohol supply in the village and stopped tobacco being given to children. They had contributed to the improvement of waste management, and Māori school attendance had risen.

Council delegates of Tamatea, Horouta, and Rongokako Māori councils in General Conferences said that there was still an urgency to establish hospitals in Native districts and to provide nursing training for Māori girls (Hutana, Ngata, & Kumeroa, 1903, in

AJHR G-1, p. 4). Therefore, as a local governing body, the Māori councils were, in Carroll's mind, performing their role well and were in a prime position to also regulate practicing tohunga. Law academic Māmāri Stephens questioned whether Ngata and Carroll felt that their support for the Bill was more for a political show or just superfluous, as the tohunga were perhaps out of the scope of the courts (Stephens, 2011). However, the many discussions in Parliament on the Tohunga Suppression Act provided a higher platform to discuss Māori health, which remained a significant concern (Stephens, 2011; NZPD, 1907, Vol. 521).

In 1902, Māori Parliament (Kotahitanga) gathered at Waimatani on the East Coast, for a presentation given by Maui Pomare. He identified two types of tohunga; one group, who prescribed rongoā (herbal remedies), and the other group who only used incantations, cold water, and external treatment. Pomare argued that cold water treatments caused many Māori to die of blood poisoning and pneumonia. Peter Buck, the health officer working under doctor Pomare, said that the old tohunga were learned men of the iwi (tribe); they were graduates of the "ancient schools of learning", however, once they passed, they were replaced by the "modern quack or sham" (Cody, 1953, p. 61).

In 1904 Pomare wrote:

...as one who sees the incalculable harm done to Māori populations by tohunga, I beg the government to act at once and pass a measure forer abolishing this demoralising practice of witchcraft. I say the curse of the Māori race is the tohunga. Get rid of them, and we will save 20 percent of the children who die annually (Cody, 1953, p. 65).

These tohunga Pomare referred to were not the tohunga of old, who practiced with intention and a great understanding of Māori spiritual knowledge; these were what he believed to be imposters. Pomare drove the 1907 Tohunga Suppression Act to aid the health of Māori, although this was often perceived as Pomare selling his culture for politics. It was said that, by generally sweeping the hand over all with this Act, those tohunga who were not charlatans would potentially be challenged for their authenticity and charged if they could not prove it. Many tohunga took their knowledge to their graves, and the tikanga they carried went with them (Cody, 1953; Lange, 1999; NZLI, 7 EDW, VII, 1907, No.13).

Regardless, for some the need to act fast and hard was the only way forward. The Attorney General, Dr Findlay said in the second reading of the Tohunga Suppression Act that although the Māori Councils were given autonomy under the Bill Provision of the Māori Councils Act in 1900 to produce by-laws about constricting the practice of tohunga. Findlay reported that he believed these by-laws were ineffective and the need for a stronger legislative enforcer, such as the Suppression Bill was required (1907, p. 373, Legislative Council).

Dr Findlay referred to Rua Kenana, the Tuhoe prophet, as “mischievous”. He felt the Tohunga Suppression Bill would stop Rua and his mysticism, and anyone else who was misleading Māori by pretending to possess supernatural powers (1907, p. 373, Legislative Council). On the contrary, Mr Wigram, representing the Christchurch area, felt that there were no issues of concern over the tohunga in his area. Therefore, he stressed that the Tohunga Suppression Act was not warranted. He also suggested that the Bill be called “The Māori Superstition Bill” to protect Māori from the exploitation and the perils of superstition and to remove the word “tohunga” (Wigram, AJHR, 1907, p. 402, Legislative Council). This suggestion was not taken any further, instead the interest seemed to lie in the definition of a tohunga and the justification for legislation to stop tohunga from practicing.

Native Minister James Carroll presented the Tohunga Suppression Bill for its second reading in August 1907. Carroll said that the Tohunga Suppression Bill provided a legal mechanism for punishing any person who pretended to be a tohunga, or who gathered Māori around him by preying on their superstition or credibility, or who misled or attempted to deceive Māori by professing that they had powers that could treat or cure any disease or could foretell future events (1907, AJHR – H, p. 373, NZLII, 7 EDW, VII, 1907, No. 13). At this reading, many of the Pākehā politicians wanted to amend the Bill to include a more precise description of what a tohunga was, yet Carroll felt that it was better to leave as described previously in the Bill. Māori politician Wi Pere defended Carroll’s retort to Dr Findlay:

There is some Māori tohunga who do their best to alleviate the sufferings of members of the Māori race, but sometimes the tohunga has an obscured motive. He professes to be possessed of these powers to curse the various ailments of humanity, to seek himself a wife or who will ask for payment in whānau taonga such as a pounamu mere, and others who practice witchcraft or makutū, ‘his God

is Hā, the god of the destruction of human life. Io is the creator of life, the creator of heavens, earth, and sea' (1907, p. 373, Legislative Council H).

Wi Pere supported the clause in the Bill that stated no one could be prosecuted under this Bill without the Native Minister's consent, because he noted that the Native Minister would determine whether the tohunga in question was under the control of Io or of Ha. Pere agreed with Dr Findlay regarding Rua Kenana, as he felt Rua was misleading those that followed him, telling them to sell everything they owned. He felt Rua was "exciting a bad spirit" that needed to be stopped by the law of the government (1907, p. 373, Legislative Council H).

There were historical accounts recorded in the book *Mihaia*, written many years later by Judith Binney, Gillian Chaplin, and Craig Wallace, that defended Rua Kenana's village in Maungapohatu. They stated that Maungapohatu set a standard of how a village should be presented. Rua Kenana impressed the many visitors that came to Maungapohatu. Many accounts mentioned how clean and hygienic Kenana's village was (Binney, Chaplin, & Wallace, 2011). Each whānau had their own house, and each house had to be kept clean, with the wood stacked neatly, all dust around the fireplaces removed, toilets cleaned, and animals placed in pens. Dogs were to be tied up, and horses were not allowed to be ridden in the main streets. House inspections were conducted twice a week, and fines were issued if the state of cleanliness was questioned. Water was brought into the village via a redirected stream, and three water pools were designed. The top pool was reserved for cooking, the second for washing domestic artefacts, and the third for people to bathe in. Discipline in the community, according to Binney, was achieved through the strength of their faith, their desire to live in the Maungapohatu community, and their total trust in Rua Kenana (Binney, Chaplin, & Wallace, 2011, p. 43).

The "bad spirit" Findlay accused Rua Kenana of could not be said of Kenana's sanitation expectations and regulations in his village. On the contrary, Kenana's village was an exemplar of what was recommended by government health inspectors throughout all communities, Māori and non-Māori (AJHR, H, p. 373; Native Land Settlement Act, 1907; No. 13; Binney, Chaplin, & Wallace, 2011; Dow, 2001). However, the undeniable influence of the early Māori prophets such as Rua Kenana,

over Māori intrigued and confounded government officials; Māori posing as tohunga equally angered Māori government representatives, such as Carroll, Pomare, Te Rangihīroa and Ngata. The Tohunga Suppression Act came into being for better or worse. The intentions from the Young Māori party was to improve the quality of life for Māori and, in doing so, there was a sacrifice. That detriment being customary practices when authentic tohunga stopped practicing for fear of being taken to court. One area that the Tohunga Suppression Act in 1907 had little impact upon, was the growing rate of infant mortality in the Māori population (7 EDW V11, No. 13, 1907; Voyce, 1989).

4.2 Section Two – Addressing Māori health

Infant Mortality

Dr Pomare was concerned about several Māori health issues. One issue particularly pertinent to this thesis, was his concern over infant mortality. Although health statistics were not collected before the 1800s, available observations and early census material highlighted the ages of children and their deaths. This information contributed towards Pomare's interpretation that led him to write that he believed that half of all Māori children died before the age of four at this time (Clarke, 2012; Lange, 1999, p. 33; Pool, 1991). A demographer later estimated that Māori infants were indeed dying at a rate of 400 out of 1000 births around the 1840s and 300 out of 1000 in the 1890s. This can be compared to Pākehā, who were reported to have had 77 infant deaths per 1000 in 1840 and 55 per 1000 in 1890 (Lange, 1999). More government-funded health support was needed within the Māori communities to address infant deaths and other poor health issues. While Māori argued for better health services, the establishment of Native Schools offered a more immediate health response in addition to education provision.

Native Schools

Often the role of health education, health data collection, and medication dispensing fell upon the shoulders of teachers within the native schools. The Church Missionary Society initially established the native schools, with the first being erected in Oihi (Hohi) in the Bay of Islands in 1816 under the direction of Thomas Kendall. Two years later, many other schools came to fruition in areas under the Anglican Church, then the Methodist Church (in the 1820s), and finally the Catholic Church from the 1830s. The earlier Missionary schools were taught predominantly in te reo Māori and were available to both Māori adults and children, although, initially, only male children could be students (Barrington and Beaglehole, 1974, p. 9).

H.T. Purches (1914) claimed in his book, *The England Church in New Zealand*, that the original intent of establishing missionary schools in New Zealand was to train Māori to assist their missionary work. The underlying desire, stated Purches, was for Missionaries to “Europeanise” the Māori with religious schooling (p. 11).

Upon the arrival of Bishop Pompelliar in 1838, another string of missionary schools was built around the country. In 1847, the Education Ordinance was passed, bringing more funding to the missionary schools. However, extra funding stipulated that the schools be conducted in English only, to have religious instruction, industrial training, and be inspected by government-appointed inspectors (Stock, 1899).

On the 30th of June 1858, the Native Schools Act came into place. This Act brought more funding to the native schools to the value of 7000 pounds per year over seven years. This act also stated that Māori students were to live away from their villages in a boarding situation (21/22, Victoria, 1858, No. 65). Between 700-800 Māori attended schools funded by the government in the 1850s, but numbers were dwindling. Many missionary schools were a force in the 1860s due to the New Zealand wars causing turbulent times for many in the Northern regions (Barrington and Beaglehole, 1974, p. 9).

An amendment to the Native Schools Act occurred in 1867. It reiterated that the purpose of the Native Schools was to educate the native and half-caste children and the government were to provide for the “establishment and maintenance of schools”. Village inspectors would be allowed access to examine the schools to see if the funding was being used appropriately, the land was required to be donated by Māori and the money was given towards the teachers’ salaries (31, Victoria, 1867, No 41). In his role as Resident Magistrate and Native Land Commissioner for the South Island, Alexander Mackey wrote in his government report in 1868 about how difficult it was to get Māori in the South to pay their school fees. Mackay said this might have been due to resentment and frustration over the sale of Stewart Island in 1864, and broken promises to build schools and hospitals for Māori. Therefore, paying school fees was likely to have been perceived as a further indictment to Māori in Te Waipounamu (AJHR, 1868, No. 6, p. 13).

The next amendment to the Native Schools Act came four years later in 1871, whereby the Governor was able to grant financial aid to the native schools with no contribution from Māori towards the buildings or the teachers' salaries. However, this Act allowed the Governor to request land as an endowment for the funding of their schools. Trustees of the endowed land were set up as they were given the right to lease land for 21 years, and the profits made from the land were to be used for the native schools (35 Victoria, 1871, No 55). In 1877, the Education Act was passed to provide further education provision via the establishment of the Department of Education. Although the Act was not compulsory for Māori, it actively encouraged Māori families to send their children to public schools if the school regulations facilitated Māori entry; however, many whānau Māori (Māori families) still resisted enrolling their children in the public schools (Butterworth, 1993). Therefore, it fell back on the shoulders and pockets of Māori to organise a native school in their community; the Ministry of Education did not make this easy. Māori communities would be required to get at least ten Māori to petition to the Minister of Education to secure a native school for their community. They then were needed to provide two acres of land and to sign over the title to the government, and contribute towards the cost of the building. Once this was done, they would have to maintain, on average, 30 tamariki on the role at the school. In 1880, a *Native Schools Code* was written that set out the rules and regulations to guide the native schoolteachers in the education of Māori pupils (AJHR, 1880, H-1F).

In the same year, James Stack wrote a report on the NZ Native Schools in the South Island after inspecting all native schools between 1879 and 1880. He wrote of 12 established native schools and they were: Wairau, Waikawa, Mangamanu, Kaiapoi, Little River, Rapaki, Ōnuku, Waikouaiti, Otago Heads, Port Molyneux, Riverton, and Colac Bay (AJHR, 1882, n.p). Waikawa and Wairewa were closed at the time of his report. The latter, due to fever epidemics in the area that led to high student mortality, and whānau vacating the rohe (area). Overall, Stack reported that most of the schools were clean, and the pupils well-disciplined in their attire and hygiene; they were also quiet and well behaved. He praised the teachers for their attention and commitment to their schools and pupils, as most teachers had never received formal education under this system before (Barrington, 2008; Bryder, 2001; Dow, 2001; Lange, 1999; Simon, 1998).

Kaiapoi Native School was erected in 1863 but struggled to obtain the funds to open until 1866. More native schools were constructed post 1866 in the South, the next being on Ruapuke Island (Southeast of Bluff) and Riverton, followed by one at Ōtākou Heads (Bird, 1951, p. 26). In 1879, there were 57 native schools in total around the country, all initially under the control of the Native Department. Once the Education Act was activated, native school control was then allocated to the Department of Education, while regional education boards managed public schools (Simon & Smith, 2001, p. 9). In 1884, James Pope published *Health for the Māori: A manual for use in Native Schools*. Pope intended this manual to help Māori equalize Māori health with non-Māori by accepting what Pope termed as “simple rules of health” that advocated for prevention over cure (Dow, 1995, p. 33). School became binding for Māori to attend in 1894; until then attending school had been optional.

Although the Education Act in 1877 stated teaching instructions were to be given in English, many native schoolteachers initially allowed Māori language to be used in the classroom to assist their teaching. Eventually, Māori language became strictly forbidden in the school arena and, in later years, students were punished for speaking Māori at school (Bird, 1951; 41 Victoria, 1877, No. 21; Simon & Smith, 2001). In 1904, W.W. Bird (2001) took over from James Pope’s position as the Inspector of Native Schools and Bird acknowledged the role of the teachers in the schools in terms of addressing and supplying medical treatments to the Māori pupils and their families:

It is only but right that a few words should be added in recognition of the praiseworthy efforts made by our teachers and their wives to assist the sick Māoris, both children and adults in the various villages. Their services, given gratuitously, are in almost daily demand, and the right thing they do unobtrusively is very considerable (Simon & Smith, 2001, p. 230).

From 1909, higher numbers of Māori attended public schools than native schools. Many factors made the decision to attend closer and fully established public schools more straightforward, including: there were more public schools closer to Māori kainga (villages); delays waiting for education inspectors to arrive on horseback; students having to travel long distances to get to the school; and families moving around the area with seasonal work. My father, Robert Tikao, remembers his native school experience at the Rapaki Native School. He referred to the school principal and sole teacher as

“teacher”. This person held a significant role within the village, which included overseeing the health of the pupils and giving out treatments. A dwindling student role eventually forced this native school to close in 1946 (2017).

The Reverend James Stack and Native Land Commissioner Alexander Mackay both supported making education compulsory for Māori. They felt that Māori learned faster and better in public schools than native schools (Simon, 1998). Also, rolls at native schools were falling, many teachers were untrained, and most were Pākehā with Māori only holding the roles of assistants. A lack of resources and the rural to urban drift in the 1940s contributed to the decline in Māori attendance at the local Native Schools. In 1969, the remaining 108 native schools were handed over to the Education Board for management (Simon, 1998). The loss of the native schools over time meant that vital dispensaries of medication and health education were much harder to access for many of the rural and coastal villages.

The history of our native schools aligns with the development of Western health organisations in New Zealand, such as general practice and hospital services. The European education and hospital systems trumped other views of health and wellbeing and contributed to the lack of cultural knowledge and customary practices being shared (Barrington, 2008; Simon, 1999; Simon & Smith, 2001). To seek the knowledge of the coloniser did not appear congruent with keeping one’s Māori identity. Low Māori attendance at colonial health services meant that the function of the native schools, as providers of education and fundamental health needs, became more prominent. Maternity matters may have been included in the primary health needs for those in rural and isolated villages that lacked access to midwifery care (Barrington, 2008; Simon, 1999; Simon & Smith, 2001). A solution to improve Māori health and to obtain better patient compliance with treatment, was to train Māori girls to be nurses in their communities.

Māori Nurses

Pre-colonisation Māori caregivers or known nurturers in the hapū would fulfill multiple roles under the concept of tiaki or manāki (to care for others). For example, the midwife in the hapū would fulfil a number of health roles besides maternity care and would also be called to attend injuries, dress wounds, nurse the sick, and often wash and prepare the dead for tangi (Māori funeral) (Beattie, 1990; Buck, 1910, 1949; Gillies, Personal Communication, January, 2016; W. Tikao, Ngāi Tahu). Post colonisation and the legalisation of lay midwifery practices, and the introduction of both nursing and midwifery training, Māori were exposed to the categorisation of individual health roles, such as medical practitioner, nurse, midwife and undertaker. Māori re-entered the health workforce through formal training, predominantly as nurses, which eventually lead to separate midwifery training. Therefore, this section provides a brief overview of nursing in New Zealand and how the pioneering Māori nursing schemes and their instigators endeavoured to recruit more Māori nurses into the profession to address declining Māori health (AJHR, G-2a, 1885; Best, 1929; Beattie, 1994; McKillop, 1998; Rimene et al., 1998).

British-trained nurses established the first New Zealand nursing training schools in the 1890s after they migrated to New Zealand. The initial nursing training started with a one-year certificate and, by 1894, the training had progressed to three years. Male medical practitioners predominantly conducted the early nursing training; they prepared the content, delivered the practice, and set the nurse's final examinations and assessments (McKillop, 1998). Leading Māori medical practitioners and politicians, such as Pomare, Carroll, Buck and Ngata, supported the assimilation of Māori into Pākehā health practices at the sacrifice of their customary practices in order to stop the rapid decline of Māori health. They claimed that, to combat health problems inflicted upon Māori, it was best to grapple the diseases with Pākehā treatments. Māori nurses, they believed, would be best suited to spread this message to whānau Māori (Māori families) (McKillop, 1998). For a more extensive nursing history, please refer to Hester Maclean's 1932 *Nursing in New Zealand: History and Reminiscences*; Ann McKillop's 1998 master's thesis, titled *A New Work and a New Profession for Women*; and also, Marie Burgess's 1984 book *Nursing in NZ Society*.

In 1897, Maui Pomare, Te Rangihiroa, Apirana Ngata, and Tutere Wi Repa of the Young Māori Party founded the Te Aute College Students Association. They would convene annual conferences to discuss Māori issues of concern, with health, hygiene, employment, and education as frequent topics on their conference agendas. At their second conference in 1897, Hamiora Hei presented a paper on *Māori Girls and Nursing*. This paper highlighted the importance of training Māori nurses to work amongst Māori communities, and to provide health advice and health care (Te Aute College Students Association, 1897). James Pope and Hei wrote guidelines for the Education Board regarding the selection of Māori students from remote areas for nursing training (Burgess, 1984; McKegg, 1992).

In 1900, medical practitioners and services recognised the benefits of having Māori nurses in the health workforce when they saw how effective they were in liaising between the medical practitioner and the patient, and how they achieved higher compliance rates with medication and accessing medical issues (AJHR, 1903, G1; AJHR, 1905, H31; AJHR, 1908, H31; AJHR, 1910, E3; McKegg, 1992; McKillop, 1998; Maclean, 1932; Te Rangi Hiroa, 1982). Pope and Hei pitched for a larger recruitment campaign to attract more Māori into a Māori Nursing Scheme, so that more would be available to nurse in their own communities post training (Bryder, 2001; Dow, 1995, 1999; McKegg, 1992; Maclean, 1932; McKillop, 1998; Lange, 1999; Ramsden, 1990).

The Māori Nursing scheme gained support from Dr Maui Pomare and Dr Te Rangihiroa. In 1905, more Māori training placements were made available to train Māori nursing students as day students in hospitals. Unfortunately, the reality was that only a few hospitals carried through teaching Māori students and bonding them to the hospital to further their skills (Bryder & Dow, 2001; McKillop, 1998; Dow, 1999). In the South Island, the Invercargill hospital provided probation training, which bonded Māori nurses to the Health Department for some time. To the disappointment of Buck and Pomare, too few Māori took up this particular type of bonded training because they did not want to be away from their whānau and hapū throughout their probation time (Durie, 1985, 1994; Dow, 1995). Nursing scholarships were used to entice Māori to complete their nursing state examinations. The lack of hospital support for the Māori health nursing scheme and few Māori who met the qualifications required to enter the

programme led to the folding of the Māori health nursing scheme. Yet another scheme was instigated in 1911, called the Native Health Nursing Scheme, to again recruit nurses to Māori communities, ideally Māori nurses (Durie, 1985, 1994; Dow, 1995, 1999; Pomare, 1906; Te Rangi Hiroa, 1982).

While hospital nursing training continued, the challenge to employ native nurses to work within Māori villages and rural townships remained a problem. At this time, non-Māori nurses were tasked with addressing Māori health, and several non-Māori nurses did adjust their nursing practice to be more culturally sensitive and empowering (McKillop, 1998). In 1909, a Pākehā nurse became the first native nurse engaged to work at Tūāhiwi Pā in Canterbury. This nurse, however, only lasted a year and the dearth of Māori nurses remained a key frustration for the Young Māori Party, as they believed more Māori nurses would improve the health outcomes and health education given to Māori (Lange, 1999, p. 168; Dow, 1995, 1999; McKegg, 1992; Maclean, 1932).

In the South Island, Rena Te Au from Colic Bay qualified at Invercargill Hospital in 1914 and became a Native Health Nurse in the Otaki area. It was challenging for the Native Health Nurses trained under a Western biomedical model, as the perspective of illness and care for patients conflicted with a holistic Māori approach. Pākehā nurses were said to be sticklers for the biomedical model. However, Māori nurses were perceived by non-Māori to be influenced by the “native mind” and thus biased to their own Māori health practices and values. Māori nurses were criticised for not taking a strict approach with their patients and were encouraged to use the skills they had been taught disregarding their cultural knowledge (Department of Health, 1984; Durie, 1985; McKegg, 1992; Marsden, 2003; Lange, 1999). This discounting was seen again in 1909 when the Native Health Inspectors and officers were replaced with district nurses who were designated to Māori settlements, often remote with minimal access to doctors. Māori nurses were not considered to be useful to the nursing pool, as it was believed that Māori nurses would not be able to be objective in their care (Durie, 1985; McKegg, 1992; Marsden, 2003; Lange, 1999). The first registered Māori nurse, Akenihi Hei, disputed these negative comments in 1908 and stated that she felt she was a reliable authority over her Māori patients. Hei stressed that all nurses need to be mindful and respectful of all cultural differences and cultural philosophies, as these attitudes

impacted on health and the delivery of treatment and care (Bryder & Dow, 2001; McKillop, 1998; Lange, 1999).

School Nurses

Another pioneering influence on public health, was the School Medical Services, established around 1912. The Department of Education employed four medical doctors to attend to the needs of all the school children. The school nursing service arose to deliver many government schemes to school children, such as immunisation against diphtheria from 1922. At this time, Māori schools were most affected by insufficient numbers of Māori nurses, with only 18 Māori available to visit Māori schools and deliver vaccinations and health care (Dow, 1995). Thus, the task fell on teachers at native schools to provide both education and health care to their students. Therefore, it can be assumed neither were able to be carried out to an excellent standard given the enormity of the responsibility (Dow, 1995). School nurses and pioneer teachers in the native schools were the eyes and ears in the Māori community for potential health concerns. Yet, they were unable to address the concerns held by the health practitioners for those too young for school. This next section explores what Māori health initiatives arose from the 1920s that inspired the concept of “by Māori for Māori”.

4.3 Section Three: Initiating for Māori by Māori from 1920

The earlier Māori health initiatives and research highlighted the injustices and inequalities that continued for Māori in health and welfare into the 20th century. The pioneer nursing schemes and the proactivism of the Young Māori Party and other advocates for Māori health and wellbeing tried hard to change the tide of assimilation and dominating medical and social practices. Instead of giving up, Māori continued to initiate programmes and schemes to better themselves and to survive. These Māori led programmes provided the platform that influenced more Māori health programmes to advance (Cram, 2009; Smith, 1999, 2004).

The critical areas of concern for both the Department of Health and Māori representatives continued from the previous century, were combating infectious diseases, addressing hygiene and sanitation within the less than adequate dwellings that housed more people than was believed to be healthy. The discussion of health initiatives from 1920 onwards in this chapter highlights the perpetual condoning of Western health philosophies and practices and shunning customary health knowledge and rituals to aid the comprehension of how the Department of Health and the establishment of nursing training and nursing schemes continued to suppress the rights and identity of Māori (Cram, 2009; Smith, 1999, 2004).

The Public Health Act

The 1900 Public Health Act was initially enacted in 1872, which activated the establishment of provincial and local health boards. These boards were charged with notifying the government about infectious diseases, sanitary issues, quarantine and vaccination. In 1876, a central Board of Health came from an amendment to the Act that provided the Governor with an overview of health. The local health boards enforced health regulations and, with the smallpox epidemic fresh in the memories at this time and the threat of the plague coming through India, New Caledonia and Australia, the government was forced to pass the 1900 Public Health Act. The Act

established the Department of Public Health, of which Dr Maui Pomare was the Māori health medical officer.

In 1920, the administration of New Zealand's public health went through a restructure and the Department of Health was established. This department partitioned health priorities into seven divisions: public hygiene, nursing, dental hygiene, child health, school hygiene, hospitals, and Māori hygiene (Kai Tiaki, 1921). Dr Te Rangi Hīroa was appointed the Director of Māori Hygiene and this division remained until 1931, when it was disbanded and the work of Hīroa and his colleagues was spread amongst the work of the other six divisions. The Māori Councils became the Māori Health Councils and continued to enforce bylaws as prescribed by the Department of Health concerning sanitation and hygiene in their local Māori communities until 1945, when lack of funding caused their demise (Hill, 2004).

A survey by Harold Turbott Gisbourne's Minister of Health conducted preliminary comparative studies of Māori and Pākehā in 1928–1929 and again in 1935 to quantify the inequalities between Māori and Pākehā with tuberculosis. Although, this research was about tuberculosis, it highlighted the inequality across the gamut of health for Māori. Turbott produced a report to the Ministry of Health in 1935 following his survey with Māori in the East Coast suffering from tuberculosis. He investigated the clinical, social, and housing aspects of tuberculosis and the prevalence of Māori with tuberculosis in the East Coast district. Turbott argued that the rates of tuberculosis for Māori had been previously under-reported. His survey results highlighted that many of the Māori with tuberculosis were living in a state of poverty, malnourishment, and in overcrowded homes. These conditions were usually associated with an increased risk of the spread of tuberculosis. The health statistics at this time and Turbott's survey showed that the mortality rate for Māori with tuberculosis was ten times the rate of Pākehā with the disease. Turbott's intentions with his survey and his report was to stimulate discussion and action by the Labour Party in government at the time to reduce the health inequalities between Māori and non-Māori, with a specific focus on tuberculosis (AJHR, Session 1, H-31, p. 3; Bryder, 1991; Dow, 1999; Lange, 1999).

Turbott's report also said that over 25 percent of Māori illnesses were not receiving any medical care. Too few Māori, he stated, were birthing in hospitals, with most babies born at home among the whānau with little concern, except when things would

occasionally go wrong and then the reality of the delay and travel to seek medical help drove infant mortality up. Turbott supported action to improve the living standards of Māori to that of the Pākehā community. He felt that isolation of Māori with tuberculosis from their whānau and hāpori (community) by continuing with tuberculosis huts (the government provided portable tuberculosis shelters) to keep sick family members with tuberculosis out of their whānau homes was having a positive impact on the reduction of disease transmission to other whānau and community members. Turbott sought government endorsement for active immunisation across large areas to prevent any further outbreaks, and to contain those with tuberculosis in their region. He initiated the tuberculosis immunisation of infants and school-age children across the whole of the East Coast region between the years of 1931 to 1935.

Turbott teamed up with Te Puea Herangi from 1936 when he worked in Hamilton as a Medical Officer under the South Auckland Health District. Turbott and Te Puea worked on hygiene standards, while Turbott continued his work on tuberculosis and fronting the inoculation campaigns against typhoid and diphtheria. Turbott turned his focus to child health and in 1940 he became the director of the Health Department's Division of School Hygiene (AJHR, 1937, Session I, H-31; Dow, 1999).

Nearly 90 percent of Māori prior to 1930 lived in rural areas, with a few Pākehā farming families situated nearby. Doctors were not attracted to reside and practice long-term in these isolated areas and, consequently, lengthy travel was necessary if in need of medical treatment. The cost of travel and incurred medical expenses meant that too few utilised these distant services, leading to exacerbated illness and death as the outcome. High medical costs were a frequent reality around the country, and often an issue raised in the Royal Commission inquiries for the government to address (King, 2004; Lange, 1999; Mackay, 1891; Te Rangihiroa, 1982).

Hospitalisation of Birth

During the depression of the 1920s and 1930s, medical expenses remained high and beyond the budget of many, including Māori. Women were consequently seeking out midwives instead of doctors to take care of their maternity needs. Dr Doris Gordon was one of the key instigators in forming the Obstetrical Society and, in 1927, swayed obstetricians to be more vocal in their advocacy for the hospitalisation of births. Gordon pushed for doctors to educate the public that birth was dangerous and the safest place for birth was in a hospital. In 1929, the Obstetrical Society appeared to have a change of heart when they advocated for a Māori maternity hospital. Unfortunately, however, such a hospital was not to promote the use of Māori maternity knowledge but was instead to encourage more Māori women into the hospital setting, where they would be treated and cared for under European midwifery practices (Mein-Smith, 1986, p. 41). For further and more in-depth reading on maternity care and the hospitalisation of birth refer to the writings of Mein Smith (1986), *Maternity in Dispute, New Zealand 1920-1939*; Chick and Rodger (1997), *Looking back, moving forward: essays in the history of New Zealand nursing and midwifery*; and J. Stojanovic (2003), *Leaving your dignity at the door: maternity in Wellington 1950-1970*.

The New Zealand Nursing Journal in 1930 published an article by K.S. Goodfellow, titled, *Bi-monthly Report of the NZ Obstetrical Society Obstetricians and the Emergency Māori Case*. This article encouraged nurses working amongst Māori to read Elsdon Best's book, *Te Whare Kohanga (The Nest House)*, to gain better insight into Māori birthing customs. Therefore, Māori driven knowledge remained suppressed while Pākehā historians and academic writers became the experts. Nurses and other health practitioners were to seek reference and understanding of cultural matters pertaining to customary maternity matters from non-Māori authoritarians (Best, 1929).

As the years advanced, the evidence of Māori customary birthing practices became almost obsolete. Bruyere (2012) surmises that the “medical model has served to dehumanise the sacred birthing experience” by minimising the value in its retention (p. 42). A *Commission of Inquiry into Maternity Services* in 1937 was one of the few pieces of literature that commented on a common Māori birthing practice being to kneel

or squat on the floor to birth; a position not endorsed in this inquiry as best practice. The report clearly articulated that, in a hospital, beds were considered a more civilised place to birth (Palmer, 2002; King, 1983). In 1942, the government printed a new edition of Maui Pomare's *The Māori Mother and Her Child* in English and Māori. Maui's widow, Mildred Miria Tapapa Woodbine Johnson, wrote the foreword in this edition, which primarily tried to coerce Māori women to accept the Pākehā health and hygiene practices over their own. It was government endorsed and promoted through the health services. This gives a glimpse into 1940s how movement away from customary birthing practices was shown to be accepted and even promoted by prominent Māori women (Dow, 1995).

The Women's Health League, Te Rōpū o Te Ora, originated in Rotorua in 1936 with a district nurse called Miss Robina Cameron. Their focus was primarily to promote fellowship and understanding between Māori and European women, with a strong emphasis on the health of Māori women and children (King, 1983). Te Rōpū o Te Ora enjoyed an active membership throughout the 1940s. Leagues were set up throughout New Zealand comprised of Māori women, including Dame Whina Cooper, who joined Te Rarawa ki Hokianga branch while living in Panguru in Hokianga. By 1950, there were 165 league branches. Yet, this was when the League faced a challenge from one of its originators, Nurse Cameron, who wanted all the branches to be under her charter and not shared with other Departments, like Māori Affairs. Eventually, the Minister of Māori Affairs, Ernest Corbett, called a national conference in 1951 to raise the question of forming a national organisation that would bring women together under shared interests, such as craft and motherhood, and for the overall wellbeing of the Māori mother and child (King, 1983, p. 169).

After relocating from Hokianga to Auckland, Dame Whina Cooper attended the national conference and was nominated as President of a new organisation that became known as the Māori Women's Welfare League (MWWL) with Te Puea Herangi by her side as Patroness. MWWL emerged to provide support, guidance, and a voice for Māori mothers all over Aotearoa (King, 1983, p. 170).

Cooper traveled to both North and South Island Māori communities, promoting the League and encouraging the establishment of new branches of the League. She also talked about the state of Māori health and issues that needed to be addressed, such as

hygiene in the home, the offensive nature of alcohol, and child-rearing practices. Cooper's push was that education came from the home, particularly from mothers. She urged mothers to look after themselves, their homes, and their whānau, making a commitment that the League would be there to support them do so (King, 1983).

The MWWL was acknowledged by scholar Mason Durie (1998) in his book, *Whaiora Māori Health Development*, as a body of vigor in the delivery of Māori health services, and the oldest active Māori health organisation (p. 58). The League supported the need for culturally appropriate health clinics and major Māori health campaigns for the betterment of Māori women. Although the critical priorities of the League were clearly around Māori mothers, domestic motherhood and infant care, it was not obvious in the literature if the League discussed customary birthing practices.

The Minister of Māori Affairs, Matiu Rata, issued a challenge to the Māori Women's Welfare League at their Annual Conference in Wellington in 1975. He wanted the National Council of the League to conduct a research project looking at the "role, status, and opportunities for Māori women in New Zealand" (Murchie, 1984, p. 11). Rata was concerned about many things related to the welfare of Māori women, including employment opportunities, education and training, and how traditions impacted the position of wāhine Māori in New Zealand.

The MWWL rose to the challenge to deliver a research project and because hauora (health) had been a strong theme for the League since its inception in 1951. One of the aims of the League was, and remains:

...to foster an interest in health matters by providing opportunities for discussion on all phases of the health of the Māori... (Murchie, 1984, p. 12).

The MWWL advocate that wāhine are the center of the whānau. Therefore, the wellbeing of wāhine is vital to ensure she is supported in her role as nurturer. In 1977, the League established a Research Unit through funding from the Department of Māori Affairs and hired Whetumarama Werata as the Research Director to carry out the household survey investigating the health status of Māori women over the age of 15 years (Murchie, 1984, p. 12). Unfortunately, the research cohort did not include wāhine from Te Waipounamu, nor did it explicitly address the loss of Māori birthing

knowledge and traditions. It did, however, highlight the health aspirations of a large number of North Island wāhine Māori. The research report was titled, *Rapuora* and it recommended the establishment of Marae-based health centers. These centers would be better positioned to provide more Māori health promotion and health education materials aimed at Māori by Māori, more Māori health professionals and Māori representatives on the hospital boards, rongoā Māori (Māori herbal medicines and practices) and primary health care (Murchie, 1984; Durie, 1998).

Implementation of some of the MWWL's Rapuora Research came 10 years later in 1987. The then Director-General of Health, George Salmond, advocated for the acceptance of Māori traditional healing alongside, or complementary to, western medicine (Dow, 1995, p. 235; Metge, 1976, p. 94). Salmond's request then waited another five years until 1993 before this occurred. Ngā Ringa Whakahaere o te Iwi Māori was officially launched and provided a professional network of traditional Māori healers as a body of health practitioners to work either independently or alongside other health services. They wanted Māori healing to be recognised and protected. Ngā Ringa Whakahaere o te Iwi is another pivotal group in the resurgence in rongoā Māori and healing in maternity care (Ahuriri-Driscoll et al., 2015; Durie, 1998; Ngā Ringa Whakahaere o te iwi Māori et al., 2008).

Discrepancies between Māori and Pākehā health continued to grow. Attention to the growing gap between Māori and Pākehā health was highlighted with revealing figures being produced by the National Health Statistics that prompted a further study addressing the Māori Standards of Health between 1955 and 1975. Dr Eru Pomare, the grandson of the late Dr Maui Pomare, was given the task of writing a report on the findings, in which he ascribed poor Māori health to the Māori lifestyle that accounted for many issues with obesity, smoking and alcohol (Pomare, 1980; Pomare et al., 1995).

In 1984, Oranga Māori (Māori Health) was given precedence by the government when it was viewed as one of the government's four health priorities in 1984–1985. This came as part of the Health Department's focus on having a culturally appropriate and sensitive approach to Māori Health. The Minister of Health at this time, Aussie Malcolm, wanted health professionals to honour the Health Board Association's protocol of handing over the afterbirths to whānau Māori. Malcolm also wanted to get district nurses to allow Māori to care for their sick Māori relatives in their own homes.

In this same year, when Labour came back into Parliament, a health promotion strategy was written that continued the government's commitment to improving Māori health via health promotion and in particular uplifting the confidence and identity of Māori (Durie, 1994, 2001; Dow, 1995, p. 234; Ratima, 2001).

Most Māori health initiatives did appear to show some interest in Māori women's health and that of their infants, but none that were so bold as to mention or address adopting Māori birthing practices based on Māori birthing knowledge. It appeared in the 1980s and 1990s that birthing was best approached using the biomedical model. The Ministry of Health seemed occupied on what they deemed as more pressing health issues for Māori at this time, which was smoking, diabetes, and obesity (Durie, 1985, 1994, 2001; Hill, 2009; Ngata & Te Rangi Hiroa, 1986).

Kupu Whakarāpopoto (Summary)

The common Māori health ailments prior to 1840 that appeared in the literature penned by anthropologists and medical practitioners appears to be: skin rashes, eye diseases, tooth decay and rheumatism. These conditions can be associated with the Māori lifestyle which was as hunter-gatherers. The use of fire and eating fibrous diets again contributed to the types of common ailments recorded at this time (Woon, 1839). The missionaries noted that Māori pre-1840 managed their pregnancies and births very well; they often reported Māori were far better at childbirth than European women. The settlers did not consider learning Māori customary birthing practices to assist their own births (Owens, 1972). Instead, the assimilation to the European lifestyle continued and with no teaching on how to manage these significant changes to their social and lifestyle habits, Māori at this time struggled (Diefenback, 1843; Martin, 1845; Owens, 1972).

It is easy to grasp how difficult this time period must have been for te iwi Māori mentally, physically and spiritually. They were vulnerable; displaced, dispossessed and many inflicted with new diseases brought from abroad. This was a scenario common throughout Aotearoa at this time but in particular for Ngāi Tahu. The battle over Te Tiriti o Waitangi breaches, the non-supply of schools and hospitals as promised in land transactions, the restriction to their mahinga kai sites, the non-committal to land reserves and inadequate land portions often unviable for economic growth added to the weight Ngāi Tahu had to carry (Anderson, 1991; Tau, and the Ngāi Tahu Trust Board, 1991; Waitangi Tribunal, 1991). Trying to fight against this wave of disempowering change must have been overwhelming.

Royal inquiries were undertaken (1879 and 1886) and commissioner after commissioner came to assess the concerns of Ngāi Tahu. Each report replicated the prior findings that reiterated that Ngāi Tahu had been treated dishonourably. Ngāi Tahu needed more land to live off and make an income from, and the Crown needed to deliver on its promises signed in the Tiriti o Waitangi (AJHR, G-7, 1891). Members of Ngāi Tahu hapū were collectively giving any money they had to send representatives to Parliament to fight for their joint grievances (Mackay, 1988; Matiu, 1891). In exasperation, Ngāi Tahu chiefs were left to wonder when, if at all, the government would honour the Tiriti o Waitangi promises made in the land purchases. Ngāi Tahu

wanted what they signed for in the Tiriti to be treated as equal citizens, access to mahinga kai sites (traditional food sites) and to remain rangatira (chiefs) over their taonga (treasure). However, it was not missed from iwi archives that Ngāi Tahu suspected that the Crown were waiting for them to become extinct, and all Crown promises would be nullified (Anderson, 1991; Dacker, 1994; Ministry of Justice, 1998; Mackay, 1988; Matiu, 1891, AJHR, G7).

Florence Nightingale, the British nurse who was asked by Governor Grey to provide guidance regarding Māori health, gave the best advice to Grey without even leaving her bedside. Nightingale utilised quantitative data, her nursing skills and her war experience to insist that Grey and the New Zealand government be more proactive towards Māori health. She directed Grey to not assimilate Māori as this would be most detrimental to their wellbeing (Keith, 1987; McDonald, 2004; Grey, 1860).

Pioneer hospitals were established in New Zealand; not to fulfil promises made to Māori in land transactions but to meet the needs of the growing and paying settler communities (Bryder, 2001, Dow, 2005; Wood, 1883). The early hospital settings were basic, sterile, expensive, away from Māori communities and generally unwelcoming for Māori (Bryder, 2001; McKillop, 1998). Māori continued to become unwell and treatment was expensive and often inaccessible. Airborne infectious diseases were a real threat for Māori due to the changes in housing and transition off their homelands (AJHR, G-2a, 1885, AJHR, G1, 1903; Dow, 1995). Poor sanitation and housing ventilation magnified the problem and led to many Department of Health schemes to try and rectify the problem but not without a sense of “dirty Māori” from non-Māori seeping through the settler society. Māori were often criticised for not adhering to the sanitary laws imposed by the government. This inferred that Māori were incapable and perhaps ignorant of what is good for their health. The emotional and physical state of Māori at this time was compromised and the ability to remain steadfast waivered.

The Young Māori Party, on a national level, drove the importance of Māori health improvement to both Pākehā and Māori but their efforts were both praised and scorned. For instance, the Tohunga Suppression Act of 1907 was put in place to protect Māori, but it also contributed to the decline of authentic tohunga practitioners and other customary Māori practices, such as those applied in pregnancy and birth (AJHR, 1903, G1; Pool, 1977).

The native schools provided basic access to health treatments but were also pivotal as an eye into the health of the Māori community (Barrington & Beaglehole, 1974; Butterworth, 1993). Māori nurses were another attempt by the Young Māori Party to lure Māori into nursing training to grow the workforce of qualified Māori nurses then able to return to their communities to address Māori health (Dow, 1995; Durie, 1985, 1994; Pomare, 1906). This proved harder than first realized, as the racism within the hospital and training services made it difficult for Māori nurses to maintain their cultural integrity and feel valued within these nursing schemes (Mein-Smith, 1986; Palmer, 2002). From the 1920s, more Māori-led health initiatives began an attempt to address specific and general Māori health concerns, yet the revitalisation of customary birthing practices did not appear to be a focus over this time.

The following chapter looks at midwifery training through the Bachelor of Midwifery degree. It also considers how the midwifery profession is shaped by their working conditions and the changing demographics in our Māori communities. The Māori midwifery workforce necessitates a greater commitment by the maternity profession and training establishments to learn and implement traditional Māori birthing practices into the midwifery scope of practice and midwifery curriculum (Ramsden, 2002; Simmonds, 2011; Stojanovic, 2010; J. Te Huia, Ngāti Kahungunu; Waerea, 2011).

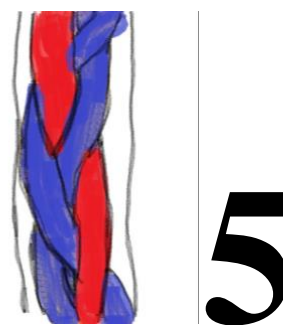
The intent for this chapter is for Māori and non-Māori midwives/midwifery tutors to not view it as an impossible task to include more Māori birthing knowledge into what has already been described as a “packed” midwifery curriculum or a busy work schedule. The goal is for them to see it as an opportunity; a much needed and exciting change that will uplift their midwifery practice and potentially improve the poor health and social statistics that continue to demoralise Māori. Incorporating more Māori customary birthing knowledge in midwifery will honour the fundamentals of biculturalism in midwifery training and the professional delivery of maternity care in Aotearoa.

This chapter acknowledges there have been, and still are, many legends within New Zealand’s midwifery profession who have fought hard to advocate, develop and nurture the midwifery workforce in sometimes contestable environments where midwives have had to hold onto their autonomy. Māori midwives have also had to tolerate challenges and these experiences add a vital strand to the overall narrative. The late Kukupa

Tirikatene summarised the importance of all individual threads contributing to this knowledge base in his whakataukāki (proverb):

E kore e taea e te whenu kotahi ki te raranga i te whāriki kia mohio tātou ki a tātou – the tapestry of understanding cannot be woven by one strand alone (2010).

This whakataukāki can also imply that one strand can not dominate others and that the other strands of knowledge and thought need to be included and honoured. Collectively the many strands will make something stronger, robust and unique to that collective. If this was to be a kono (food basket) or a whāriki (woven mat), it has been prepared with all the previous chapters in this thesis and now laid before the reader in preparation for the following chapter. Chapter five delves deeper into specific Ngāi Tahu birthing traditions and why I believe renaissance of this particular kaupapa will make a significant difference to the hauora and mauri of Ngāi Tahu in the coming years and will only enhance the current Bachelor of Midwifery degree if mātauranga is embraced fully by curriculum creators.



Whakamāmāe / Māori Midwifery Today

Ko te ke ehu, Te whare patahi, E hui te rangiora...

Ko te Tīmatatanga (Introduction)

While the previous chapter examined the historical impact of colonisation on the health and wealth of Ngāi Tahu, this chapter moves forward along the timeline and focuses on Māori in midwifery practice and education today. Therefore, continuing the pūrākau (story) of Māori in maternity in the present context. It investigates through interviews with Māori midwives, midwifery students, and midwifery educators what changes they believe have been made or still need to be made to improve the provision of mātauranga Māori into midwifery training and the professional practice environment.

The first section speaks to the themes raised in the Māori midwifery interviews addressing Māori midwives as minorities in their already strained profession and in their communities. Māori midwives diverged in their views, being either confident and expressive with the promotion of customary Māori birthing practices or a little hesitant due to a lack of knowledge about their Māori heritage, inclusive of te reo Māori and customary birthing practices. Both can be advocates of a unique Māori midwifery knowledge. Like the revitalisation of te reo Māori me ngā tikanga (Māori language and customs), Māori midwifery approaches align with the reclamation of mātauranga Māori

(Māori knowledge), which is considered a taonga that needs to be protected by both Māori and Pākehā in Article II of the Tiriti o Waitangi (Calman, 2011; Moon, 2002; Orange, 2015). However, both can be advocates of a unique Māori midwifery knowledge. Like the revitalisation of te reo Māori me ngā tikanga (Māori language and customs), Māori midwifery approaches align with the reclamation of mātauranga Māori (Māori knowledge), which is considered a taonga that needs to be protected by both Māori and Pākehā in Article II of the Tiriti o Waitangi (Calman, 2011; Moon, 2002; Orange, 2015). The midwives interviewed anticipated that the interest in Māori practices will grow and that Māori and non-Māori midwives should prepare their midwifery practice now to meet the foreseeable demand for tikanga enriched births. This section concludes with a discussion on the Māori midwifery support networks that are essential for providing a collective voice; not always in harmony but having commonality.

Section two considers the content of the midwifery curriculum through the eyes and hearts of Ngāi Tahu midwifery students undertaking the Bachelor of Midwifery degree at one of the two South Island tertiary providers. This section is a journey that initially provides a brief overview of the historical commencement of formal midwifery education in New Zealand before moving the lens forward in time and through the eyes of Ngāi Tahu midwifery students as they share their trials and tribulations associated with their midwifery journey.

5.1 Section One: Māori in Midwifery Today

This section focuses on Ngāi Tahu midwives and Māori midwives working in Te Waipounamu and relevant issues they consider to be hindering the inclusion of Ngāi Tahu customary birthing knowledge and practices within contemporary maternity services. Using a semi-structured interview schedule, I recruited Māori midwives, Māori students, and Māori and non-Māori past and present midwifery lecturers and past and present midwifery heads of the South Island midwifery schools. This cohort came from Christchurch, Dunedin and Invercargill, and their experiences within midwifery ranged from minimal to extensive. A kaupapa Māori approach to interviewing, as outlined in chapter three, was supplemented with a reflexive thematic analysis with kaupapa Māori theory at the fore during this process. This section sought to find out: “What does being Ngāi Tahu in midwifery mean? What does the incorporation of mātauranga Ngāi Tahu relating to birthing traditions look like for Ngāi Tahu midwives? Where is the empowerment for Māori midwives, Māori whānau, and what needs to occur to achieve equity for Māori in midwifery?”

Being a minority in the workforce

Māori midwives are very aware of the weight they carry as a small cohort of the wider midwifery workforce. According to the research participants, being a minority is a concern because the risk of burnout becomes greater. Their job satisfaction also wanes with greater demand but an inability to assist whānau eager to have a Māori midwife deliver their pēpi (baby) (J. Te Huia, Ngāti Kahungunu, Māori midwife; R. Chisolm, Ngāti Porou, Māori midwife).

The Midwifery Council Workforce Survey (2019) identified 3226 midwives who have annual practicing certificates. The midwifery workforce ethnicity is predominantly New Zealand European (2737), with 197 identifying primarily as Māori, 122 with Asian ancestry, 75 Middle Eastern/Latin American/African ethnicity, and 45 Pacific peoples (Statistics New Zealand, 2018; New Zealand Midwifery Council, 2019). Māori figures rose to 317 when midwives were asked to state their second or third cultural

affiliations (Midwifery Council of New Zealand, 2019). With 15,000 of the 56,000 babies being born every year in New Zealand identifying as Māori, the overall number of Māori midwives is grossly disproportionate (Statistics New Zealand, 2018; New Zealand Midwifery Council, 2019). The Māori population is projected to grow by 16.2 percent, compared to a growth of 13.5 percent for non-Māori, between 2015-2030. This population growth is due to Māori having a higher total fertility rate of 2.34 compared to non-Māori women, who have a fertility rate of 1.9. In addition, Māori have a greater youth population with many falling into the main reproductive age groups between 15 to 44 years. Māori women start having babies earlier also, between their mid-teens to early twenties, with the greatest number of Māori mothers birthing between the 20 to 24-year age group. Most non-Māori women have their babies when they are aged between 30-34 years of age (Crengle & Ratima, 1993, 2013; MOH, 2011).

Ngāi Tahu follow a similar pattern to the overall Māori demographic with an expected population rise. However, with low numbers of Māori midwives available to meet the existing demand this will only intensify with a population growth (The Office of Te Rūnanga o Ngāi Tahu, 2018; Statistics New Zealand, 2018; R.Chisolm, Ngāti Porou, Māori midwife) Māori midwives shared that they already feel the weight of having to turn whānau away as they are at capacity. The luring of more Māori into midwifery training and into the maternity profession is essential in the provision of more maternity options for whānau of Ngāi Tahu and the wider Māori population.

Despite incremental increases in the Māori midwifery workforce, we only have 5-12 Māori midwives joining the national workforce every year by re-entry to the profession or as a new graduate. This is not a sufficient increase to match the maternity demands of the Māori population (New Zealand Midwifery Council, 2019; Ratima et al., 2007). The District Health Boards (DHB) are also aware that their maternity services are under-represented in ethnic midwifery staff, in particular, Māori midwives make up only 7.2 percent of the current DHB midwifery workforce. Although this is a slight increase on 2013, more Māori midwives are needed both as core midwives and as lead maternity carers (LMC) (New Zealand Midwifery Council, 2019; Te Rau Matatini, 2018). Half of the midwifery participants in this research were working for a DHB and the other half were working independently as LMCs. Those that worked for the DHB maternity units explained that they did this because it was more conducive to their whānau lifestyle. Others chose the DHB setting because they were new to midwifery,

and wanted to gain work experience in the hospital before stepping out as an independent midwife. They all said, that although they were aware of their minority status, it felt more intense under the umbrella of the DHBs. All midwives in this study reached out to Māori midwifery networks locally and nationally to gain cultural support. Of the 20 DHBs in New Zealand, 11 had a lower proportion of Māori midwives, while four DHBs (Whanganui, West Coast, Wairarapa, and South Canterbury) had no Māori midwives within their workforce (The New Zealand District Health Board, 2018). Demographic planning indicates a need for a midwifery workforce that better reflects the ethnicity of their patients and working environments that prioritise growing the Māori (and Pacific Island) midwifery workforce with adequate professional and cultural backing in place (Health Workforce New Zealand, 2013; Medical Council of New Zealand, 2019).

Māori midwives in this study reported they did not feel culturally supported in their workplaces.

I have actually spent time here (maternity unit) listening to midwives locally who say why should there be a separate Māori representative? There is not a separate Indian one, and there's not a separate Chinese one. I have lots of Māori clients and they all think I am wonderful. Yet none of them get what it's like to be that minority and have choice, and that one of those choices reflect you. I think that is critically important to the wellbeing of the woman I work with (P. Nei, Ngāi Tahu, Māori midwife).

Māori midwives feel frustrated when they hear their midwifery peers downplay the uniqueness of their culture by grouping all ethnicities into one genetic basket and dismissing the importance of midwives that reflect cultural diversity. The other key point made was about choice and having the right of options to choose from.

As a minority, as Māori within the health profession, it's so easy for us to understand that we don't treat everyone the same, we treat everyone as individuals. Why is it so difficult for those statements from health professionals to say, "I treat everyone the same"? The culture of their family and their ways of being, which is different for every person you meet (P. Nei, Ngāi Tahu, Māori midwife).

Feeling like your peers do not understand you or are culturally naive can make the workplace culturally unsafe. Considering the average time in the midwifery workforce is currently 15 years, addressing cultural support may be essential to retaining the Māori

midwifery workforce (New Zealand District Health Board's Midwifery Workforce Report, 2018; New Zealand Midwifery Council, 2016, 2019). Māori need Māori colleagues and peers to provide cultural support. This will help Māori midwives to feel more enabled to offer cultural practices to whānau. This increased collegial assistance will enhance confidence in their skills and mātauranga Māori. Maintaining strong Māori networks also contributes to reducing the isolation reported by the research participants. Participants described a lack of networks and support that contributed to burnout in the profession (R. Chisolm, Ngāti Porou, Māori midwife; A. Clarke, Ngāi Tahu, Māori midwife; J. Te Huia, Ngāti Kahungunu, Māori midwife; T. Stone, Ngāi Tahu, Māori midwifery student). McKenna (2003) and Namukombe, Ekong and Sun (2017) agreed that mentoring is a necessary tool in professional development and relieving stress and anxiety within nursing and midwifery. They acknowledged that midwifery mentoring promotes an effective teaching and learning relationship. Collegial support, as mentioned above, stimulates greater awareness of personal values and beliefs and boosts confidence by eliciting a greater sense of responsibility (Ekong and Sun, 2017; McKenna, 2003).

In 2009, Te Rau Matatini (the National Centre for Māori Health, Māori Workforce Development, and Excellence) conducted a national research project titled, *Ngā wawata o ngā Neehi Māori me nga Tapuhi Māori – Responses from Māori nurses and midwives nationally*, that looked at three key areas: attraction and recruitment; professional development; and leadership for Māori nurses and midwives. A mixed-method study was actioned with a series of one-day workshops over 10 regional centres, including Christchurch and Dunedin, in 2008, and a national online survey. 153 Māori nurses and midwives took part in the workshop and 160 participants completed the online survey. The online survey addressed, among other areas of interest, the professional development for practicing midwives to remain active in their careers, to become confident leaders, and to support those who were already in management roles to extend their skills.

The key points raised in this research were the need for improved and more focused marketing of nursing and midwifery, targeting all ages with appeal to those in rural, local and regional areas. It noted that comprehensive support is important throughout midwifery practice. This support should commence at the pre-entry level and include more guidance on career options. More academic training that aimed at preparing Māori

for nursing or midwifery degrees. The findings also emphasised a need for greater Māori content in the nursing and midwifery curriculums, more Māori peer support and mentoring, more Māori nursing and midwifery tutors, with mentoring, academic and social supports throughout their midwifery training and Māori midwives practicing in the profession (Te Rau Matatini, 2009).

Overall, the survey found that Māori midwives desire more Māori-directed support and opportunities to take part in Māori-driven and directed forums about Māori kaupapa within their professions. New Māori midwifery graduates wanted the same peer and mentoring support to continue beyond their first year of practice. Both new graduates and experienced Māori nurses and midwives also sought better access to te reo and tikanga Māori, mātauranga Māori and Māori models of health (Te Rau Matatini, 2009). This study is consistent with the findings in this doctoral research, inclusive of Māori midwives and new midwifery graduates requiring better access to te reo and tikanga Māori, and Māori models of health within their practice.

Sally Pairman (Personal Communication, October 10th, 2016) expressed in her interview that the NZ College of Midwives are acutely aware that there are more Māori women of childbearing age and yet the majority of practicing midwives are non-Māori. Pairman then surmised that the job of the New Zealand College of Midwives is to equip all midwives to be able to work appropriately with Māori women and their families. Pairman believes the development and implementation of the midwifery partnership contribute towards better provision for Māori women and whānau.

A shortage of working midwives

Low numbers of midwifery graduates, combined with midwives leaving the profession due to dissatisfaction with working conditions and poor pay, have culminated in a shortage of midwives in the profession. This midwifery gap will only become more pronounced over the coming years until more students graduate and enter the midwifery workforce, and more Māori midwives sustain longer midwifery careers (Gulliland, 2017, 2018; Macandrew, 2019; Rankin, 2019). Currently, Māori midwives represent nine percent of the overall midwifery workforce. To raise this figure to 20 percent by

2020 as preferred by the Māori Health Workforce Unit, would require conjuring up an extra 320 midwives immediately to work alongside the 200 already registered (Baxter, 2019). A twenty percent increase of Māori midwives working all over Aotearoa would be a progressive step towards addressing the gross inequity in the health workforce. Baxter (2019) and Curtis (2012) state that health workforce inequities lead to inequity in health outcomes. Reid and Robson (2006) claim that the longstanding disparities in health outcomes subdue the responsiveness of health systems to poor Māori health. Health inequities can become normal, expected and potentially accepted, which can make it even easier to lessen the action for change. Baxter (2019), Curtis (2012), Reid and Robson (2006) advocate greater diversity in the health workforce will have multiple influences on improving Māori health outcomes.

Three quarters of the total number of midwives (2364) work in the North Island, with a significantly smaller proportion of 270 (8.9 percent) employed in Canterbury (New Zealand Midwifery Council, 2016; The New Zealand District Health Board, 2018). This is relevant, given the Ngāi Tahu population being largely based in Canterbury and further south. Broughton (2019) reported that Canterbury's maternity service is persistently understaffed, and it is predicted that another 16 midwives will leave the workforce over the next ten years. The Canterbury District Health Board's (CDHB) maternity strategy 2019-2024 identified the issue of staff loss and the need for greater midwifery recruitment to meet the immediate needs of nearly 6000 babies being born in Canterbury a year (2019). This figure, according to Broughton (2019), will rise in the coming years, and the CDHB maternity strategy needs to plan for future population growth.

The New Zealand District Health Board (NZDHB) (2018) acknowledged that the midwifery workforce in DHBs is exposed to demanding workloads and a rise in complex patient presentations. Since 2010, the national DHB midwifery workforce has been in decline (4.3 percent drop in midwives); and from 2013 we have been seeing the disequilibrium of an expanding population and a diminishing midwifery workforce. The NZNO Chief Executive Memo Musa concurred with the staffing predicament, stating in 2016 that most of New Zealand's larger maternity units are facing staffing shortages and are stretched (Kai Tiaki Nursing New Zealand, 2016, p. 9).

The DHB's are already seeing increased sick leave for midwives and they have large numbers soon to retire from the profession. Also, midwives are lured to case loading midwifery, because they have greater independence and flexibility. That said, the majority (50.7 percent/1532) of midwives are core midwives employed by the District Health Boards, with 36.6 percent (1107) being paid by the Ministry of Health (MOH) as case loading midwives or LMC's (New Zealand Midwifery Council, 2016; The New Zealand District Health Board, 2018). The MOH (2019) expressed that child wellbeing continues to be a high priority for them and they are committed to improving outcomes for women and children. The MOH budget for years 2018 and 2019 reflected this commitment by tagging 4.5 million dollars to fund rural and regional workforce training. The MOH's 2019 budget financially provides for the implementation of more initiatives to sustain the midwifery workforce by strengthening the pathway into midwifery and continuing this support throughout the career of the midwife. Māori leaders have provided views to the MOH on improving maternity services for Māori wāhine and their whānau (2019). This is the beginning of what appears to be a committed conversation between the MOH and Māori. The focus is towards a collaborative approach to improving continuity of care for Māori. Ten million dollars has also been allocated in the latest budget over four years to expand the Māori health workforce, which includes wraparound support for Māori student nurses and midwives. Overall, the MOH is working towards a sustained midwifery workforce by improving the pathway into training and providing optimum support to the midwives (MOH, 2019).

Constant advocating for better pay

Poor pay reciprocity makes it difficult for midwives to maintain a level of autonomy and longevity in their careers, especially those servicing the rural and remote areas of Aotearoa (Māori midwife, Personal Communication, 2016). The College of Midwives went to court in 2015 and sued the government under the Bill of Rights Act 1990 for paying midwives less based on their gender. They could not bring an action in terms of the Equal Pay Act 1972, due to a clause in the Act that ruled out self-employment (Jones, 2015; Winter, 2015). The College of Midwives alleged that the MOH breached

gender rights in terms of pay equity by highlighting that midwives earned approximately 60 percent less than male-dominated professions who have a similar level of expertise and leadership (Bryder, 2003; Exton, 2008; Jones, 2015; Winter, 2015). Two years later, the College of Midwives withdrew the pay equity claim for an interim fee increase of six percent and the opportunity to co-design a funding model for LMCs to address their ongoing poor pay issues. The then Health Minister, David Clarke, agreed that the DHB midwives were initially paid more than LMC midwives and this, he believed, was unfair. LMCs were not unfamiliar with putting up a fight for their pay equity plight (Bryder, 2003; Exton, 2008; Jones, 2015; Winter, 2015). In 1993, LMCs took a case to court under similar circumstances seeking equal pay for equal value through the Maternity Benefits Tribunal and were successful. However, LMCs since this court win have only managed another increase in 2007 with small increments over the following years (New Zealand College of Midwives, 2017).

In 2017, the College of Midwives and MOH collaborated on a co-designed funding model that calculated a fair gross income for case loading midwives/LMCs. That agreement provided a certain amount of income, taking into account a birthing fee (close to \$1000), miscarriages, caesarean sections or other birthing complications that led the client to be transferred out of the midwife's care. This resulted in the midwife unable to charge for her services leading up to the birth complications. Therefore, the co-designed blending payment model had a base payment to cover the midwife's business affairs, such as expenses for travel, coverage for second midwives, incentives for midwives working in areas that struggle to employ staff, and monetary compensation for being on call (MOH, 2019).

Again, in the 2018 budget, the government only chose to honour some parts of the co-designed model put forward by the College of Midwives. Then only granted an extra \$103 million for the profession over a four-year period. The College of Midwives' deputy chief executive, Alison Eddy, argued that this increase was not enough towards pay equity, and the College was seeking double that amount. Midwives are being forced to leave their jobs due to unsustainable work conditions and inadequate pay (Broughton, 2019; Forester, 2019; Mussah & Mathewson, 2015; Rankin, 2019).

The ex-Chief Executive of the New Zealand College of Midwives, Karen Gulliland, expressed that it is a serious situation that midwives' call for a pay increase has been

largely ignored by government officials. Currently, the ratios of midwives to mothers and babies is unsafe because the government has not factored the babies into the midwifery ratio (Gulliland, 2018). Babies, not just mothers, require care from the midwife. Hospital midwives are often allocated five mothers, including each of their babies. With this ratio of 1:10, the risks relating to adequate care and support for both the mother and child, and for overworked midwives, are evident. Better employment packages are needed, including a higher wage to entice midwives not currently registered to restart their registration, and return to employment, alongside retaining the midwives currently employed. Other issues include ensuring that working conditions are realistic, that appropriate professional support is provided, and that broader policy imperatives address issues such as safe ratios between midwives, babies, and mothers (Broughton, 2019; Kai Tiaki Nursing New Zealand, 2018; Williams & Woolf, 2019).

More support and less discrimination of Māori knowledge and practices in maternity sector needed

Traditional Māori birthing knowledge has been forgotten by many Māori, and is only actively practiced by small hapū collectives to varying degrees around the country. Māori midwives can feel uncorroborated not only by other non-Māori midwives but also by a few Māori elders working for government departments who may have limited awareness of traditional birthing techniques but are given a greater platform to make decisions that can be potentially detrimental to Māori midwives who use traditional Māori maternity practices (J.Te Huia, Ngāti Kahungunu, Māori midwife).

One midwife received a letter of complaint from the maternity department and was asked to come in and discuss the complaint, which was concerning her use of a traditional Māori birthing technique over standard midwifery practice. She prepared herself for the meeting by doing more research to support her course of action at this particular birth, and explained:

But the thing that got me was they had a kaumātua present and he said one thing that was devastating and that was in his 70 years he had never heard of that practice and it is kind of demoralising that it made me feel unsafe and no matter how much research I had done on delayed cord clamping, colour, Apgar score

which was a Pākehā technique. I had nothing in writing to support the traditional Māori practice and I didn't have a person to support me – it was frightening (J. Te Huia, Ngāti Kahungunu, Māori midwife).

Another Māori midwife shared an incident at her workplace where frozen sanitary pads are given to mothers to use to soothe their perineum post birth. Due to a mechanical issue with a separate freezer, it was felt appropriate for these clean sanitary pads to be placed in a food freezer that was located in the patient's lounge. When the Māori midwife raised this as being cultural inappropriate and a chilly bin or another non-food freezer needed to be located in the hospital, she was told that the Māori expert at the hospital had said this practice was okay.

I think it makes it (upholding tikanga in our specialty) so much more difficult when we're dealing with our own inconsistency (P. Nei, Ngāi Tahu, Māori midwife).

Another Māori midwife said that some whānau Māori do not ask for traditional Māori birthing practices to be included in their birthing care because they do not know what to ask for. This response can get interpreted as whānau not wanting to use traditional Māori birthing practices, but this is not always the situation, explained a research participant. They may ask for these practices more if it was offered to them. Therein lies another obstacle, because many midwives have no, or limited, knowledge around specific Māori birthing practices and, therefore, do not offer this knowledge pathway. Whānau Māori can then remain oblivious to their cultural birthing practices as “people don't know what they don't know” (J. Te Huia, Ngāti Kahungunu, Māori midwife).

This midwife's comments are similar to Māori midwife Te Huia's experiences with young Māori women, whom she said were sometimes indifferent when asked if they would like a Māori midwife to care for them (2015). J. Te Huia (Ngāti Kahungunu, Māori midwife) claimed that often young Māori women appear to have little or no understanding of what a Māori midwife does differently to a non-Māori midwife. She explains that when these women were asked if they would like to learn and incorporate traditional Māori birthing practices into their birthing plans, they often refuse or become frightened that in doing so they could be putting their unborn child at risk. These perspectives are not unsurprising and appear to arise from years of social

conditioning sometimes via their mothers, grandmothers, midwives, society, friends and whānau, that perpetuate that birth is safest in hospital under the care of predominantly non-Māori practitioners (J. Te Huia, Ngāti Kahungunu, Māori midwife).

The concern is that traditional Māori birthing knowledge may be seen as not needed due to the low uptake initially by whānau Māori; but if more knowledge is available via midwives and maternity resources, then whānau Māori would be more aware of what these birthing practices are and, if they preferred, could include into their birthing plans. Currently, there is still a dearth in Māori-focused maternity resources, including traditional Māori birthing practices and rituals that promoting this knowledge is inaccessible for many Māori communities.

Being Māori in the midwifery profession adds another level of pressure

Hawkes Bay attracts the highest number of Māori midwives with a total of eight. Canterbury has five Māori midwives who offer some Māori traditional birthing practices (Ministry of Health, 2011; Midwifery Council 2016; J. Te Huia, Ngāti Kahungunu; Tikao, 2013). There is a need for more Māori midwives across Aotearoa who, through training and professional support, feel competent and confident to provide customary birthing practices to whānau.

Another reality for many Māori midwives interviewed for this research, is a sense of being undervalued for the dual roles they bring to their work. Māori midwives are committed to ensuring their patient and whānau wellbeing is prioritised, while at the same time meeting their contractual employment agreements. They would like recognition of the cultural input they provide within their clinical roles, and they would like to have more peer support and receive mentoring and clinical and cultural supervision (Māori midwife). This is consistent with the findings of Te Rau Matatini (2009), which highlighted that while mentoring is embedded in midwives' first year of practice, new graduates wanted this to continue.

Climbing over the whakamā (ashamed/embarrassed) barrier

Māori midwives acknowledge the whakamā barrier that exists for some of their Māori patients. They reported that their patients would not ask questions because they felt inadequate and too whakamā to ask the practitioner for clarification. In 2010, the MOH released a report on the Hospital-Based Maternity Events for 2007. This report found that Māori women felt a lack of empathy from general practitioners which hindered them from asking pertinent questions about their birth care (Ministry of Health, 2010).

These findings reiterate the importance of the communication of maternity information and care to be delivered with more awareness of how health literate people are, including how people understand both the written and spoken details about health information provided by their health professionals. These issues are important to ensure that people can make informed decisions about their care and also that they feel safe enough to ask their questions (Makowharemahihhi et al., 2014, Ministry of Health, 2010).

Māori women aged under 20 who received proactive support at their initial assessment did access maternity services sooner (Makowharemahihhi et al., 2014, Ministry of Health, 2010). Young Māori women are often perceived as not wanting to engage in maternity care and perhaps appear a little ambivalent towards their own health needs. Maternity practitioners play a pivotal role in assisting hapū wāhine and their whānau to navigate the maternity pathway well informed and aware of their choices

(Makowharemahihi et al., 2014). This research highlighted that the first maternity contact for Māori women is their general practitioner to determine pregnancy and after this initial appointment, 92 percent of Māori women enrol with a midwife as their LMC. The tension with this engagement is 52.1 percent of Māori women do not enlist their LMC until they are into the second trimester of their pregnancy (Dixon, 2014; Scott, 2014). Dixon et al. (2014) and Burton et al. (2000) claim that late engagement with an LMC can lead to higher rates of foetal mortality in utero and post-birth, higher rates of smoking and reduced ability to encourage wāhine Māori to have recommended screening to assess foetal wellbeing.

Reasons for engaging later than non-Māori were debated by Māori midwives at a Ngā Maia o Aotearoa Hui in 2016. Māori midwives advocated that their clients felt that they only needed assistance from the LMC when they were further advanced in their pregnancy. This thinking was often associated with experienced mothers who did not see the need for what they would perceive as early enrolment with an LMC. Other wāhine Māori registered late with an LMC because they preferred a Māori midwife or a midwife who would be culturally responsive, which took time to arrange (Māori midwives, 2016; Ngā Maia o Aotearoa Hui, 2016). In other research, Dowswell et al. (2010) identified a few potential reasons, including: busy lifestyles, unplanned pregnancy, teenage pregnancy in mothers who did not know they were pregnant or who may have been in denial of their pregnancy. It could also be that wāhine Māori do not know when they need to register with an LMC or may have difficulty working their way through the LMC pathways or not able to find an LMC that suits their needs.

Approximately ten percent of Māori women birth in primary maternity facilities, while most non-Māori birth in a secondary and/or tertiary facility (Maternity Report, 2017). Primary units do not have the specialist care readily available like the secondary units, therefore, primary birthing units have lower rates of episiotomies and do not offer inductions or epidurals. The current rate of Māori women to undergo a caesarean section, induction or have an epidural are much lower than the rate of New Zealand European women, which is at 34 percent for women aged over 35 and 42 percent for women over 40 years of age (Ministry of Health, 2010). The overall rate for caesarean sections in New Zealand is 25 per 100 live births or one in every four women. Māori women like to leave their facilities quicker than non-Māori, on average staying only 1.7 days (Ministry of Health, 2010) and Māori women feature strongly in the three

percent of women who have home births (Ministry of Health, 2019). Māori are also less likely to need assistance with their birth (76.5 percent) than any other ethnic group (Ministry of Health, 2011, 2015; Health Start Workforce Project, 2018; Sadler et al., 2002).

Engaging in culturally relevant antenatal programmes and initiatives

Māori have low attendance rates at antenatal classes, and this was perceived as another risk factor for poor maternity outcomes, although Dwyer (2009) and Gagnon & Sandall (2007) emphasised that attending antenatal classes is not sufficient to prevent poor birth outcomes like low birth weight. Interviews with Māori midwives showed they were very aware of the push by the MOH and other non-Māori midwives to get Māori women to attend antenatal programmes and to enrol with an LMC early. These Māori midwives understood that the education and monitoring received during antenatal programmes can reduce the risk of perinatal and birth conditions such as high blood pressure, gestational diabetes, preeclampsia, anaemia, depression and maternal ill health (ACOG, 2014; Allen, 2000; Curtis et al., 2007). Some argued that this trend of late enrolment and poor antenatal attendance, in addition to their own professional experience, showed that wāhine Māori require more professional care in the latter stage of their pregnancy and postnatally. Therefore, they suggested that instead of trying to persuade wāhine Māori to attend antenatal classes early, utilising the LMC funding to obtain longer engagements with wāhine Māori postnatally may be beneficial (Ngā Maia o Aotearoa Hui, Wellington, 2016; J. Te Huia, Ngāti Kahungunu, Māori midwife).

Some Māori women have said that they would prefer an integration of Māori birthing knowledge within their antenatal programmes. Others prefer stand-alone antenatal programmes with a total focus on Māori birthing tikanga and spirituality, and be marae-based or provided through a Māori Health Service (Curtis et al., 2007; Dwyer, 2009; Gagnon & Sandall, 2007; Ngā Maia o Aotearoa Hui, Wellington, 2016). This variation in response could be the ease of access for some Māori who prefer to attend a hospital setting nearby. Some may feel embarrassed by their lack of cultural awareness. Those in favour of a stand-alone antenatal programme said they would also like the classes to

be informal, led by Māori and have the involvement of elders, encouraging all whānau members to attend, with a stronger emphasis on vaginal births (Russell et al., 1997; Papps & Ramsden, 1996). The preferences mentioned above are the same that arose out of a maternity service review in 1999 regarding maternity care. The results indicated then that care was not whānau-centred and did not meet the needs specific to Māori (De Joux, n.d; Dwyer, 2009; National Health Committee, 1999).

Māori-led maternity initiatives make stronger and longer connections with whānau

Today there are a small number of marae-based health clinics and independent Māori midwifery services that provide ante and post-natal care alongside other mainstream maternity and health services. These health clinics are predominantly situated in the North Island in communities with greater Māori populations, such as Auckland, Rotorua, Taranaki, Gisborne and Hawkes Bay (Gee, 2018). According to Wepa and Te Huia (2006), there are varying levels of connection and cohesion between services and local iwi and other groups such as the Māori Women's Welfare League, general practitioners, and district health boards. There have been, and continue to be, pilot Māori antenatal programmes in Nelson, Marlborough, Taranaki, Wainuiomata and Waikato, to mention a few locations, funded under the local District Health Boards and supported by Māori health organisations and staff. Evaluations from these programmes have proven that they are indeed popular and well attended (Taranaki District Health Board, 2018).

Māori midwives throughout the country are facilitating wānanga to help wāhine hapū (pregnant women) to make resources such as ipu whenua (placenta containers) and whītau muka (a cord to tie around the umbilical cord) for their pēpi. A recent antenatal initiative in Taranaki based on Māori values is called Hapū Wānanga and operates from the local marae. This programme originated within the Waikato DHB and, given its early success following high attendance by local Māori women, was expanded throughout Taranaki DHB as a pilot for six months (Groenestein, 2018; Te Karere, 2018). Tawera Trinder is one of two Māori midwives delivering the Taranaki hapū

wānanga programme and believes it has already proven its worth by being well attended and has received positive appraisals from participants (Groenestein, 2018; Te Karere, 2018). Participants attending Hapū wānanga led by Māori midwives reported that they enjoyed being at the marae for their antenatal programme, and being with other whānau Māori (Groenestein, 2018; Te Karere, 2018).

Another Māori antenatal programme in Wellington, called Kaupapa Māori Antenatal and Kaiāwhina Education (MAKE), is a series of hui administered by BirthED. This is an organisation of midwives, lactation specialists and kaiāwhina (assistants/workers/carers) who share their skills in the MAKE programme. The organisation provides a traditional Māori option within their service involving three-day hui for wāhine hapū and their partners to learn about birth through the stories of their tūpuna. This links wāhine hapū to their whakapapa (ancestry) alongside current childbirth and parenting knowledge. BirthED run practical workshops making whītau muka while partners and support persons have breakaway sessions to share thoughts and stories and make ipu whenua (BirthED, 2018).

Elsewhere, in Te Waipounamu, there are forums for learning customary Māori birthing knowledge. For example, traditional Māori birthing wānaka/antenatal workshops have been run separately or within their birthing education programmes; Te Hou Ora in Dunedin and Te Puawaitanga ki Ōtautahi Trust in Christchurch with the Whānau Mai wānanga (Te Puawaitanga ki Ōtautahi Trust, 2018). Te Huia (Ngāti Kahungunu, Māori midwife) reiterated that kaupapa Māori antenatal programmes need to be offered and sustained to grow Māori awareness and interest in customary Māori birthing practices. This, Te Huia (Ngāti Kahungunu, Māori midwife) stressed will lure more Māori to enrol and complete antenatal programmes.



Te Puawaitanga
ki Ōtautahi Trust

Whānau Mai

Kaupapa Māori Antenatal Education



Artwork by Robyn Kahukiwa

Whānau Mai will focus on:

- **Pregnancy Health**
- **Labour & Birth**
- **Kaupapa Maori Birthing Practices**
- **Breastfeeding & Early Parenting**
- **Incorporating Oriori, Rongoa, Mirimiri, Karakia**
- **Muka & Ipu Whenua**

Whānau Mai is a journey through pregnancy, childbirth and the early weeks of parenting that incorporates a Māori world view and traditional Māori birthing practices.

Whānau Mai is for pregnant wahine and her whānau.

This programme is delivered in two sessions, one in early pregnancy (before 24 weeks) and followed by a late pregnancy session covering Labour and Birth, Breastfeeding and Parenting.

Whānau Mai Tuatahi (Pregnancy)

August 15 at He Waka Tapu
September 15 at Te Puawaitanga
October 16 at Oxford Terrace Baptist Church

Whānau Mai Tuarua (Labour, Birth and Parenting)

August 31 at Te Puawaitanga
September 26 at He Waka Tapu
October 27 at Te Puawaitanga

Contact us for venues and dates and/or to register:

Reception@omwml.maori.nz; Phone (03) 344 5062, 0800 66 99 57;

More info on our website: www.whanauoraservices.co.nz

Figure 4. Te Puawaitanga ki Ōtautahi Trust Kaupapa Māori Antenatal Promotional Poster, 2018.

Finding champions of traditional Māori birthing knowledge

Non-Māori midwives are also championing the learning of traditional Māori birthing knowledge throughout Aotearoa. One example of this, is the 2016 midwifery conference, *Cultivating Our Roots: Let the Tree Flourish Conference*, facilitated by Rosemary Joyce who works as a doula at The Birth Centre in Christchurch. The focus of the conference was to highlight traditional Māori birthing practices and 80 midwives from across New Zealand took part in presentations and workshops addressing the implementation of traditional Māori birthing practices into their professional practice and/or maternity service.

Midwives at the conference were asked to identify the obstacles that hindered the inclusion of traditional Māori birthing knowledge into their practice. Some said they felt ignorant of what traditional Māori birthing practices were and therefore were not confident delivering cultural knowledge, others were unsure of the appropriateness of offering this knowledge pathway in all settings and at all stages of maternity care. Another question raised at the conference was, who should be delivering Māori birthing knowledge? Is it only for Māori midwives or can non-Māori midwives who want to champion this knowledge and rituals for the whānau in their care be able to and encourage them to do so? This is a pertinent query that was met with varying replies. Some Māori midwives agreed that non-Māori could and should champion Māori birthing knowledge with their whānau Māori. Other conference attendees suggested seeking out Māori midwives who were familiar with or able to acquire these skills from others before approaching non-Māori midwives who could advocate and teach this knowledge to our whānau Māori if they too had the specialty skills and competence. Some questioned whether there was a need by whānau Māori for traditional Māori birthing knowledge and commented that they did not want to force this knowledge on whānau.

Te Huia (Ngāti Kahungunu, Māori midwife) noted that some young Māori women have had fewer choices available to them regarding options in their birthing plans. Te Huia (Ngāti Kahungunu, Māori midwife) reported that many of her Māori clients are hesitant to choose customary birthing practices over hospitalisation because they are unfamiliar with these practices. Their mothers and grandmothers have often birthed in hospitals or

birthing units under the biomedical model of maternity care and have become estranged from customary birthing practices. However, this did not mean the knowledge was not needed or valued, as one participant explained:

They are not asking for it, but that doesn't mean there isn't a need for it...they don't [know] what to ask for and they are not being offered customary birthing practices because some midwives don't know to offer it (Māori midwife).

Education about Māori maternity knowledge is, therefore, essential to provide informed choices for young Māori women and their whānau. Regardless of the awareness of traditional Māori birthing practices and philosophies, all midwives still need to champion the knowledge and provide choices for whānau Māori to access Māori health practitioners and services (Wepa and Te Huia, 2006). Wepa and Te Huia stated that, “a challenge for the 21st century is for Māori women not to have their birth practices violated but validated through culturally safe practices” (2006, p. 30).

Māori midwives have been confronted by their peers for advocating for whānau Māori. A mature Māori midwife explained that she asserted to her non-Māori peers that if she was approached by a whānau Māori to be their midwife after they confessed, they were going to leave their present midwife because they felt that their cultural needs were not being met, she would have no hesitations in taking over as LMC. When her morals were questioned by her colleagues, she retorted,

It's not ethical to feel marginalised within your own country and to feel you have no choices or to be coming out the bottom of the heap because nobody is doing anything different. So, I said if my being with them helps, then I'm going to do it (P. Nei, Ngāi Tahu, Māori Midwife).

Another Māori midwife stated in her research interview that her midwifery peers denied any devaluing of their Māori clientele as they care for all their clients the same, implying that they believe they are respectful by treating everyone the same. This Māori midwife argued with this sentiment, as she felt that as a minority within the health profession, Māori mothers should not be treated the same as non-Māori and should instead be treated as individuals with specific needs and interests. She explained,

Therein lies the problem...you can't treat everyone the same...I always nurse to what greets me at the first contact, and then we go from there (P. Nei, Ngāi Tahu, Māori midwife).

Māori and non-Māori midwives can feel in conflict incorporating traditional knowledge as it is not recognised by mainstream health services. Midwives may be at risk of jeopardising their midwifery registration if they were placed in a situation favouring cultural needs over medical judgment (Joyce, 2016; J. Te Huia, Ngāit Kahungunu, Māori midwife). Māori midwifery participants agreed more professional education about traditional Māori birthing practices and rituals is needed. They also concurred that more supportive professional and greater promotion in social media of Māori maternity would help in normalising cultural differences. It was also highlighted that patients/clients' rights are to be treated with respect in all aspects of their care, as stipulated in the Midwifery Council of New Zealand Code of Conduct and the New Zealand Health and Disability Commissioner Code of rights.

Midwives said they could encourage consumer feedback or complaints to again highlight the lack of specific Māori birthing knowledge and acceptance of Māori ritual within their birthing plans. It was deemed important by conference attendees to continue working on antenatal education for whānau on traditional Māori birthing practices. Overall, this cohort of midwives argued it was important to continue to learn, to network, to collaborate and to take little steps towards making bigger changes concerning the addition of Māori knowledge and practices (Joyce, 2016). At the same conference, Moana Jackson (2017) incited health practitioners to be brave and push for change, and not to stop pushing until equality had been reached. Under the Treaty of Waitangi (1840), United Nations Declaration on the Rights of the Indigenous Peoples Articles 2, 3, 8, 11, 12 and 24, and hospital strategies, such as He Korowai Oranga (New Zealand Māori Health Strategy), it is stressed that the improvement of Māori health requires more Māori contribution, leadership, development, and equity.

Te Rūnanga o Ngāi Tahu has a hauora (health) team that has produced the Te Rautaki Hauora 2015 (health strategy) that applies to all members regardless of their place of residence. This has been developed through a series of Ngāi Tahu Hauora hui and further refined with hauora summits asking members about iwi hauora goals, future hauora funding towards Ngāi Tahu hauora initiatives, iwi members health insurance,

strategic hauora partnerships, and hauora specifically around rangatahi and kaumātua. Other information is being sought through member surveys, such as the Ngāi Tahu Living Standards, which is measuring the impact of government policies on Ngāi Tahu members' lives and getting a greater sense of what a Ngāi Tahu Living Standard is and should be.

This level of tribal hauora detail will contribute towards the education of midwives and other health professionals by feeding specific iwi hauora knowledge gathered from tribal research back to the community to assist services that would be able to tailor their practice to the expressed needs of the Ngāi Tahu community they are working with (Clarke, 2019; Te Runanga o Ngāi Tahu, 2015). Having iwi research conducted by iwi researchers is now a reality once recommended by pioneer Māori researchers and leaders to aid the improvement of Māori wellbeing. Providing our own empirical, qualitative and quantitative data, and the analysis of the same, is empowering and enlightening for Māori but for mainstream healthcare also (Mahuika, 2008; Pihama, 2008; Smith (G), 1990, 2003, 2007; Smith (L), 1999, 2000). Many Indigenous researchers have acknowledged that changes are taking place regarding global recognition to varying degrees of “cultural norms and spiritual ceremonies” (Ayers-Gould, 2000).

Māori midwives would like more professional development in te reo Māori, tikanga and mātauranga pertaining to childbirth

Participants in this study stressed the difficulty of gaining more skills in Māori maternity knowledge to enhance their professional practice. They state that there is a very small cohort of Māori midwives who can offer support and guidance on traditional Māori birthing practices to whānau and their colleagues. This cohort needs support too; to ensure more Māori midwives become competent in customary practices (R. Chisholm, Ngāti Porou, Māori midwife; A. Clarke, Ngāi Tahu, Māori midwife and Educator; J. Te Huia, Ngāti Kahungunu, Māori midwife). The current reality is that those Māori midwives with this wealth of knowledge are mature and called upon for many things within their hāpori Māori (Māori community); multiple demands on

midwives' time are contributing to anecdotal reports of high levels of burnout among this group, a problem common among midwives more widely (Te Huia, Ngāti Kahungunu, Māori midwife; Ngā Maia o Aotearoa, 2016). Māori midwives are obligated through iwi and whānau affiliations to take on greater caseloads but often at the risk of their personal health and that of their whānau (Ngā Maia o Aotearoa, 2018; J. Te Huia, Ngāti Kahungunu, Māori midwife; Kani, Personal Communication, January 2017). Again, targeted funding opportunities offer excellent networking and professional development to assist Ngāi Tahu midwives to grow their knowledge, competence and confidence in customary birthing practices. Also, to gain greater skills in te reo Māori, karakia, waiata and rauemi (resources) that will aid whānau interest in including more practices in their birthing journeys.

Tūranga Kaupapa is the nationally NZCM approved professional development offered presently. It is a six to eight-week course specifically for practicing midwives and supported by Ngā Maia o Aotearoa. A survey conducted in 2009 by Te Rau Mataora concerning Māori nurses and midwives in the workforce noted a strong desire from the participants to incorporate noho marae (marae-based activities) and wānanga. (Māori styled workshops). Noho marae as “modes of delivery” regarding learning on customary birthing knowledge within their clinical capacity. Access to specific Māori knowledge and training appeared to be dependent on the employers' understanding of the importance of these requests from their Māori nurses and midwives to them as employees, as health professionals and to their Māori patients (Baker, 2009, p. 28). There are too few registered Māori midwives and many parts of Aotearoa do not have access to any Māori midwife. Therefore, the champions of this knowledge are few and far between and their support networks are even smaller.

The unspoken value of Māori Midwifery Support Groups and Mentors

Māori midwives have, out of need and interest, created their own support networks. These networks provide professional development, a platform for the public to locate Māori midwives, space and a place for Māori midwifery students to find mentors and a cohesive voice for Māori midwives. Groups such as the Canterbury Māori Midwifery

Rōpū and Ngāi Maia o Aotearoa Regional Groups are assisting both Māori midwives and midwifery students and local whānau in the profession (R. Chisolm, Ngāti Porou, Māori midwife; A. Clarke, Ngāi Tahu, Māori midwife and Educator; J. Te Huia, Ngāti Kahungunu, Māori midwife). The nature of these groups is discussed further below:

Ngā Māia Māori Midwives Aotearoa

Throughout this chapter, I have referred to the Ngā Maia Māori Midwives Aotearoa (NMMA). This is an organisation that offers a supportive network for Māori midwives, Māori midwifery students and whānau Māori. NMMA was established in October 1993 by a group of Māori midwives drawn together by their shared interest in Māori issues and hapūtanga. As a national organisation, it provides a support network for Māori midwifery students and registered Māori midwives, hapū wāhine and their whānau (J. Te Huia, Ngāti Kahungunu, Māori midwife; Kani, Personal Communication, January 2017). The NMMA defines its directive as follows:

...to develop frameworks of practice that acknowledge the validity and significance of whānau being offered care that reaffirms Māori epistemology as being a birthright of all Māori through whakapapa (Ngā Maia Māori Midwives Aotearoa, 2018).

The NMMA facilitates the Tūranga Kaupapa Professional Development Workshops for clinicians in maternity throughout Aotearoa. Henare Te Kani, the author of the Tūranga Kaupapa programme for NMMA, produced a training package and taught a group of facilitators (seven Māori midwives) to deliver the workshops in 2017. A resource package was produced to allow midwives throughout the country to book into a Tūranga Kaupapa cultural training workshop. In these workshops, participants learn about Māori values and customary practices. The programme was written by Māori experts with extensive knowledge in midwifery. Tūranga Kaupapa has been written for midwives. The New Zealand College of Midwives has endorsed the workshops and contributes financial and educational support to the NMMA for their delivery. In 2018, Māori midwife Jean Te Huia took a new, revised Tūranga Kaupapa programme to all midwifery schools. Over 500 midwifery students attended the programmes on offer.

Response to Tūranga Kaupapa has been positive according to the evaluations received by Ngā Maia o Aotearoa and personal accounts from Māori midwifery students in this research (Te Huia, Personal Communication, 2018).

Based on the programme's successes, Te Huia prepared a strategy for all DHBs to fully support the programme in order for it to be available to all midwives. Currently, there are two Māori midwives employed as DHB midwifery advisors who are also Tūranga Kaupapa facilitators and have been offering Tūranga Kaupapa workshops to their DHBs in Auckland and Hawkes Bay. At the time of writing, the New Zealand Midwifery Council (NZMC) agreed with Te Huia's proposal and confirmed that it would make Tūranga Kaupapa compulsory for all midwives to complete on a three-year cycle. Work is also now underway to convince NZMC to make all immigrant midwives complete the Tūranga Kaupapa workshop before they receive their Annual Practicing Certificate (Te Huia, 2018).

Canterbury Midwifery Rōpū

The Canterbury Midwifery Ropu was established in 2004 with the intent to formalise a network among Māori midwives for cultural and professional support. They aimed to grow initiatives that nurtured the Māori student midwives completing their training at ARA Institute of Technology. It has approximately 60 members, with up to 32 Māori midwives and over 10 Māori midwifery students from the Otago and Canterbury regions (R. Chisolm, Ngāti Porou, Māori midwife).

At the Canterbury Midwifery Rōpū meetings, the desire to incorporate more kaupapa Māori practices into the maternity sector in Christchurch was expressed. Many of the Māori midwives in this Rōpū had worked at the Burwood Birthing Centre and saw an opportunity after the closing of the birthing unit in 2016. The Burwood Hospital birthing unit was a Christchurch icon, built to meet the demand of the baby boom post-WWII and continued to be utilised for 70 years. The Christchurch Women's Hospital in 2004 provided another maternity option and led the management of the Christchurch Birthing Unit. With bed numbers dwindling and asbestos identified alongside structural weakness in the building, it was closed and demolished. However, closure provides

opportunities for new ideas to develop. Regarding Māori maternity services, this has been the case for the Canterbury Midwifery Rōpū (R. Chisolm, Ngāti Porou, Māori midwife).

The idea of pitching a tender to the Canterbury District Health Board for a Kaupapa Māori-led Primary Birth Unit to be part of the overall redevelopment of Christchurch's maternity care was now a possibility for the Canterbury Midwifery Rōpū. The Canterbury Midwifery Rōpū approached the Health Board to gain guidance on what was required and were told to seek a needs analysis. The Canterbury Midwifery Rōpū sought the help of a private research consultant to assist them in developing a research proposal and report in aid of enhancing their tender to the DHB. Elements of the tender included completing a cultural feasibility analysis investigating specifically whether whānau Māori living in Canterbury would prefer a stand-alone primary birthing unit or a Kaupapa Birthing Ward within a hospital setting. They also considered a sizing analysis to gauge the numbers that would attend the potential unit and, finally, an indicative report on the feasibility of establishing a Māori-led primary birthing unit in Christchurch with inclusion into the primary birthing strategy for Canterbury (R. Chisolm, Ngāti Porou, Māori midwife). When member and past coordinator of the Canterbury Midwifery Rōpū, Ruth Chisolm, was asked why she believed Christchurch would be a good place to open a Kaupapa Māori Birthing Unit she responded,

I think that the majority of Canterbury (people), well, I would like to think, are open to a Kaupapa Māori facility, whether it's birthing, whether it's education. At least expose the Māori and embrace it... I don't mind (if the Kaupapa birthing unit) is for all as long as it's Māori led, determined by Māori. That, I think, would establish more than if we were bi-cultural. Let's go hard out immersion... and I think that's going to help our students be less intimidated as they are now (2016).

The MOH has set out goals to improve access, equity and health outcomes for Māori and takes its lead from the Māori health strategy, He Korowai Oranga (2014). The overall aim of He Korowai Oranga is the provision of a Māori health framework that supports the MOH and DHBs to improve Māori health (2019). The four key divisions of He Korowai Oranga include Pae Ora – healthy futures for Māori with three other contributing goals: Whānau Ora (healthy families); Wai Ora (healthy environments); and Mauri Ora (healthy individuals). This strategy will be implemented into health and social sector services through the Māori Health Action Plan. The Action Plan has

stipulated that it supports the role of mātauranga Māori in the development and delivery of health services to Māori (MOH, 2019). Therefore, the establishment of a culturally led and infused kaupapa Māori primary birthing unit, such as the one proposed by the Canterbury Midwifery Rōpū, addresses many of *He Korowai Oranga's* aims of supporting whānau, hapū, iwi and community development, and ensuring effective health service delivery.

Boulton et al. (2013) credits Māori health service providers for having the best ability to design and deliver culturally relevant services. Shifts in the government's public and health policies since the 1980s have enabled some Māori health service providers to make healthcare decisions that are consistent with the cultural values of the service, and the needs of the whānau (Boulton et al., 2013). There are several kaupapa Māori health and social service providers situated around the country but there is currently only one kaupapa ward based at Tauranga Hospital. Ward 2a uses whanaungatanga (relationships) as their model of care and pride themselves on ensuring the patient's iwi connections are acknowledged and worked with in terms of seeking support whilst in hospital and upon discharge. The care delivered recognizes the cultural values of both the patient and their whānau, incorporates their values into the patient care plan. This ward has been running successfully for 12 years and is an exemplar to how a kaupapa Māori health service can be sustained and deliverable to the needs of the Tauranga Māori community (Bay of Plenty DHB, 2018).

Kupu Whakarāpopoto (Summary)

This section commenced with the “push-pull” dynamics for Māori midwives working as a minority in a profession that perhaps has not fully recognised the cultural credentials that Māori midwives are bringing to the profession. Māori midwives are at risk of being burnt out and disgruntled by the lack of professional development and networking that is particular to their needs. Some of the reasoning for this, is the focus on midwives carving out an autonomous profession and fighting for better pay and working conditions. Meanwhile, Māori midwives have been fighting more personal battles to overcome a lack of self-belief, staying strong in their cultural values and cultural practices as lone voices in the profession; juggling the professional-Māori balance between doing right for your career and doing right for your people. Currently, these two components do not see eye to eye and will need to be addressed soon if more Māori are going to be lured into the profession to meet the current shortfall between Māori babies being born and low numbers of Māori midwives graduating. There are champions in the midwifery industry that understand, believe in and practice with a Māori heart. They value system who are both Māori and non-Māori and take it upon themselves to learn and teach customary birthing practices in their communities as part of their health role.

Māori midwives have stressed the need for more professional development that includes te reo Māori and more in-depth information on Māori customary practices. They have also highlighted the immense value of having Māori midwifery support in the community with rōpū like Ngā Maia Māori Midwives Aotearoa and the Canterbury Midwifery Rōpū. These rōpū are creating opportunities for Māori midwives to gather and grow their knowledge systems. The Canterbury Midwifery Rōpū has taken this to another level by investigating the establishment of a kaupapa Māori primary birthing unit for whānau in Ōtautahi (Christchurch) and surrounding areas.

To go forward, we need to step back and in the next section of this chapter we see how midwifery education has been shaped by our maternity history and how the training of midwives shapes the future careers of Māori midwifery students. This section speaks with Māori midwifery students to find out their perspective of being Māori and in

midwifery, and their thoughts on the incorporation of customary Māori maternity knowledge.

5.2 Section Two: Midwifery Education

In this section, the focus is on midwifery training and the responses from the Māori midwifery students, Māori midwives, non-Māori midwives, lecturers, and directors of the South Island midwifery schools. The intention is to gain an insight into what it is like being a Māori student of midwifery and what we can learn from their perspective about the inclusion of more mātauranga Māori relating to pregnancy and childbirth in midwifery education. It is also of value to ask the same from those who teach midwifery, and how they manage Māori students and kaupapa Māori (Māori perspectives) within their schools to see students through to graduation. This section also considers the views of experienced midwives Māori and non-Māori talking about midwifery education and professional development they need to upskill and sustain the incorporation of traditional Māori birthing knowledge into their midwifery practice. To start, this section acknowledges the historical narrative of midwifery education in New Zealand in this brief overview.

The backdrop to the Bachelor of Midwifery

Midwifery training in New Zealand has been as transformative as the drive for autonomy by the midwifery profession. Midwifery education has been shaped by a myriad of initiatives, including the commencement of the midwifery registration post the Midwives Act in 1904; new medical technologies that lured women into hospitals to birth; and the use of drugs, including the introduction of anaesthetics for pain relief in the 1920s and the drug concoctions of Nembutal and scopolamine (known as “twilight sleep”) given to erase the memory of childbirth pain (Donley, 1986; Mein-Smith, 1986; Papps & Olssen, 1997; Stojanovic, 2010). The new birthing stupor that sold childbirth as pain-free while making a woman semi-conscious. They required greater monitoring under medical supervision, and this turned birth from a normal physical process to a surgical procedure (Stojanovic, 2010). The higher the maternal stupor, the more medical interventions, and the more reliant mothers became on the medical profession to birth their babies (Donley, 1986; Mein Smith, 1986). With increased intervening techniques came infection.

Puerperal sepsis was initially blamed on midwives, until a health select committee, established in 1921 to examine the increased maternal mortality, discovered the correlation between sepsis and the medical instruments used in childbirth. Instead of reducing births in the hospital and venturing back into the home or delaying the use of birthing interventions, the new combative approach was the application of antiseptic techniques. These techniques did contribute somewhat to the lowering of the maternal mortality rate, but it also made women fearful to birth naturally (Stojanovic, 2010). Over the following years, the development of hospitals, hospital boards, the Obstetrical Society and the longstanding work of the St Helen's maternity hospitals, combined with the growing voice of the consumers and what they needed and wanted from a maternity service has crafted the midwifery profession, the midwifery curriculum and also the way midwifery is taught (Gilkison et al., 2016).

Up until the end of the 19th century, midwifery was taught experientially through observation and mentoring. Learning was “hands-on”. Births took place in the home with the family and were likely to be perceived as painful, yet a natural part of a woman's life. Māori have described the birth as a way of life and the survival of whakapapa. Traditionally, Māori midwives learned midwifery under a tuakana-teina (senior-junior) model. This model is the passing of knowledge and skills from one learned person to someone who has either shown potential within this area of care and/or from a whānau member who could assist with pregnancy and birth (Henry & Wolfgramm, 2018; McClean, 2011; Rawlings & Wilson, 2013).

Maternity services during this period and into the 1900s for non-Māori were provided by lay midwives, they were also referred to as “handywoman”. Some had received training overseas and would take women into their own homes for their births. There were also what was known as “lying-in” hospitals that were privately owned by doctors or midwives in urban areas (Giddings & Smythe, 2013; Manson & Manson, 1960). More trained midwives came to Aotearoa in the late 1800s early 1900s, when the rate of non-Māori birth had declined, and maternal and infant mortality was on the rise. This drove the government to make significant changes to the maternity sector. Most notably, was the commencement of formal midwifery training in 1904 with the passing of the 1904 Midwives Act. This statute effectively extinguished the role of lay midwives in New Zealand by declaring unregistered midwives, including Māori, who

delivered babies as practicing unlawfully and now deemed insufficiently skilled for the task (Donley, 1986; Gilkison, Giddings & Smythe, 2013; Manson & Manson, 1960). Midwives trained overseas and established businesses in New Zealand on their arrival here, quickly becoming a popular service choice (Gilkison, 2013). Some midwives charged a higher fee, which made it costly for Māori to access their services; therefore, they remained with the lay Māori midwives in their community (Gilkison, 2013; Hill, 1982). A particular trained midwife, Grace Neill from Scotland, established her maternity business in New Zealand, becoming a primary figure in the establishment of the midwifery registration process and midwifery education in New Zealand (Gilkison, 2013; Hill, 1982). Neill lobbied the then Prime Minister Richard Seddon to live up to his political word when he stated in his manifesto in 1904 that his government would prioritise the wellbeing of the mother and infant. With Neill's insistence and Prime Minister Seddon's word, the Midwives Act in 1904 was sanctioned alongside the first Register of Midwives (Gilkison, 2013; Hill, 1982).

State-funded maternity hospitals were launched to facilitate the midwifery training. The first hospital to open in 1905 was St Helen's in Wellington. This was an essential step in the medicalisation of birth; when midwives became subordinate to doctors and lay midwives lost their role in maternity to overseas introduced standards of midwifery care. The training at St Helen's hospital continued for another 75 years until midwifery training ventured into the polytechnics with a stronger emphasis on theory and research before clinical placement. More medical technologies were introduced, for example, ultrasound, electronic foetal monitoring, new anaesthetics, and specialised neonatal care, all of which emphasised the need for more in-depth midwifery training (Gilkison et al., 2013).

In addition to the advancement in midwifery, there was a change to the midwifery approach. This change was instigated by a consultant from the World Health Organisation, a doctor Helen Carpenter, who advised the New Zealand government that midwives needed to be more independent in their thinking, learning the skills, and being competent to make the calls on how to apply what they have learned. This learning, she recommended, should be away from the hospital setting and provided in a tertiary environment and become a postgraduate nursing specialty (Allen, 1992; Carpenter, 1972; Papps & Olssen, 1997). The move into the tertiary sector created its own set of

problems as the ten-month course was only for registered nurses and leaned more towards the theory side of midwifery, reducing the practical knowledge as experienced within the St Helen's hospitals. There was also a rising groundswell of consumers, midwives, and women's groups wanting to establish a separate midwifery profession (Donley, 1986; Gilkison et al., 2013).

A Women's Health Committee was established in 1986 to report on midwifery in New Zealand; this report gave momentum to significant reforms in midwifery education that resulted in a longer midwifery programme for registered nurses in 1989 and two years later a direct-entry midwifery programme over three years was instigated. In 1992, at Auckland Institute of Technology, the first direct entry in midwifery was offered via a three-year diploma in Midwifery. A Bachelor of Midwifery was obtainable through Otago Polytechnic at the same time and, from 1997, midwifery could only be studied as a degree at the five polytechnics in New Zealand offering midwifery training (Exton, 2008; Gilkison, 2013).

As the whakapapa (chronicles) of midwifery unfolds, the call to the midwifery profession has perhaps remained the same throughout this historical narrative to contemporary times. I now turn to examine the views of present Māori midwifery students to understand what brought them to this health profession.

Midwifery captured my heart

Even though there were a few stumbling parts in my first year, I loved midwifery. There was no way I was turning around after I did that first year. It just drew me in, mainly working with whānau. It just really made me realize that this is it. I don't have a choice about what I'm going to do because this has captivated me and captured my heart (T. Stone, Ngāi Tahu, Māori midwifery student).

For this Māori midwifery student, attending her first birth after following the mother for a year felt like a privilege. She worked alongside this whānau over the course of their pregnancy and discovered for herself how much impact a midwife can have on the whānau birthing experience. A Māori midwife recalls the reason she enrolled in

midwifery training as an epiphany while she was working with the Department of Conservation on Stewart Island:

My great grandfather was a midwife; he delivered babies on Stewart Island... I looked at myself and thought there's a good match there. And in particular, because there were no obvious Māori people practicing midwifery in Southland (P. Nei, Ngāi Tahu, Māori midwife).

Another Māori midwifery student said her mother started talking about her own birthing stories, which ignited her interest in midwifery.

I looked into this as a career and thought, this is kinda cool. It really encompasses all of the things that I enjoy. I'll be able to meet people and to advocate for their choices (D. Gibbs, Ngāi Tahu, Māori midwifery student).

The Māori midwives and students described their interest in commencing midwifery training as stemming from a desire to work with Māori to potentially improve the health experience for Māori. The Rauringa Raupa: Recruitment and retention of Māori in the health and disability workforce (2008) stated that factors motivating Māori recruitment into the health sectors fell into four categories: structural, system, organisation and individual reasons. Midwifery students and midwives in this study aligned most strongly with the individual reasons. These included prior experiences or links to the health sector, a desire to improve the health sector for Māori, and whānau encouragement and support. However, to contribute towards the health sector's responsiveness to Māori, as a student, your own cultural identity needs to be nurtured within your training institute.

Being me – means speaking te reo Māori

Recognition of te reo Māori for Māori midwifery students is crucial to how the Māori midwifery students perceive themselves and their place in the midwifery workforce. Te reo Māori is another vital skill that needs to be nurtured within their training and in the field once they have graduated. A Māori midwifery student described how these skills led to being given more scope by her mentoring midwife to connect culturally with the whānau she was assigned to in her first year of midwifery:

The midwife was happy for me to play that role because it was a way to make sure that the whānau would stay comfortable in the environment. I spoke te reo Māori to the dad. He didn't feel comfortable asking questions, but only if they were in Māori. I knew if I responded in te reo Māori, that was the only way he could be present in that environment and feel comfortable (T. Stone, Ngāi Tahu, Māori midwifery student).

The utilisation of te reo Māori aided not only the Māori midwifery student's ability to bond with the father but also the father's ability to connect with his culture at such an emotional event. The father was able to ask questions more freely in Māori directed towards the te reo speaking Māori midwifery student. Russell (2018) and Pere (2006) claimed that the ability to speak te reo Māori in day-to-day conversation was one of the four different components of strengthening someone's cultural identity and achieving a sense of belonging. Encouraging the use of te reo Māori within midwifery is twofold; keeping the official language in existence and establishing conducive rapports with whānau. Being surrounded by other Māori who are supportive of Māori values sanctions the use of cultural practices, such as te reo Māori. This support aids the promotion and affirmation of cultural identity and, in the example above, the use of te reo Māori allowed the father to feel empowered (Te Huia, Personal Communication, September 2015).

A past Māori midwifery lecturer highlighted the importance of midwifery schools addressing the needs of students with te reo Māori fluency by stipulating that their language constructs a deep sense of who they are, their whakapapa and their place of cultural standing. She was referring to students coming through Kura Kaupapa Māori education (te reo Māori immersive education) and entering midwifery training. She

challenged the training institutes by questioning if they were able to meet the needs of their diverse student body now and for future Māori students with a proficiency in te reo Māori:

How are they going to meet the needs of those coming with a very strong sense of identity and relationship to their Māori language as well? (A. Clarke, Ngāi Tahu, Māori midwife).

Sciascia (2017) discussed Māori learner success in tertiary education and emphasised the importance of culturally responsive pedagogies to deliver tertiary programmes that embed mātauranga Māori and values, such as whānaungatanga (relationships), manākitanga (care) and whakapapa (lineage) into the learning. She reiterated that culturally responsive education supports the use of te reo Māori and tikanga Māori to promote Māori achievement and keep Māori in tertiary education. The Ministry of Education strategies that cement the government's ongoing commitments to Māori education include the Tertiary Education Strategy to support education providers to improve Māori achievement. The Māori Tertiary Education framework seeks links between Māori ambitions and the tertiary systems.

Professional support for midwifery training institutes is accessible, culturally appropriate, and available to nurture Māori midwifery students. The opportunity to speak te reo Māori as a therapeutic tool inspired the following Māori midwifery student to continue down the pathway of midwifery,

I'm coming from the perspective that I'm Māori, and I'm coming into midwifery, so, therefore, I am a Māori midwife. That's my passion. That is for me a directive, so there's no question about that (T. Stone, Ngāi Tahu, Māori midwifery student).

However, not all student participants felt confident and comfortable with their ability or inability to speak te reo Māori, and this can be for some a sense of whakamā (shame) and pressure as one student noted:

I identify as Māori, I will be a Māori midwife, but my biggest barrier is te reo Māori, which I am working on. It's my goal in life to be fluent one day (D. Gibbs, Ngāi Tahu, Māori midwifery student).

Māori midwifery students are diverse in their backgrounds, upbringing, schooling and fluency in te reo me tikanga Māori. As above, some Māori midwifery students feel confident and comfortable with te reo Māori. Other Māori students are less assured, yet eager to grow their skills in this area. Having te reo and tikanga Māori programmes available to midwifery students during their training that nurture the varying skill levels would be well received, according to these students. Encouraging and honouring the use of te reo Māori with whānau who prefer te reo Māori throughout their care is another strong asset to sustain and acknowledge within midwifery training.

Feeling secure in your cultural identity can be challenging in a mainstream environment.

Some Māori midwifery students felt that being strong in their understanding of their whakapapa (family lineage) and their cultural knowledge sometimes made them feel isolated in their midwifery training and maternity settings due to having no other Māori peers with similar fluency in cultural values and te reo Māori.

In my first year, I got a bit upset. I wasn't the only Māori student there, but I was the only one who came from a Te Ao Māori perspective. Often things would come up around statistics or Māori focused questions; the white middle-class students would often challenge why Māori and Pacific Island students received additional support as students. We had an akonga group (a name for tutorial groups) that was dedicated to Māori and Pacific Island students to come together in one group, and this was challenged on a number of occasions. I thought that the tutors did not address these challenges very well... questions were raised (by non-Māori students) and then they kind of festered over the year... there was much talk about creating a Pākehā tutorial group that would exclude (Māori). It got messy and so in the end I made a formal complaint via email and when I did get a chance to talk to the tutors and students, I felt they really listened and they brought the group together (T. Stone, Ngāi Tahu, Māori midwifery student).

For this Māori midwifery student there appeared to be a lack of awareness in the wider midwifery lecturing management of the racism that came to the fore when the majority felt challenged by the formation of a separate group for Māori and Pacific Island students. Unanswered questions from non-Māori students over what they perhaps felt was special treatment for Māori and Pacific Island students meant that they delivered their negative quips to the Māori and Pacific Island students themselves. The Māori midwifery students were then left to experience the wrath of racism, process this feeling, and in this situation confront the problem themselves, followed by instigating a solution going forward. This reflects several personal experiences I endured during my nursing training in the mid-1980s and to hear of this still happening over 20 years later is disturbing. Dr Couper of the New Zealand College of Midwives (NZCM) states that they take discriminating comments and actions very seriously in training establishments and maternity institutions. Cultural competence and safety are vital to get right, implied Couper; however, she noted that she is aware that it would be naïve to believe that institutions are not void of hegemonic actions and comments (Stewart, 2016).

An ex-Māori midwifery lecturer recognised the extra demand that is inadvertently being placed on Māori midwifery students that adds to the responsibilities they are required to uphold:

I worry for our students... because there is still a smaller numbers, they're often asked to do above and beyond all the time and it's about protecting them... they have a world view that means they bring a diversity of thinking. They bring a whole other world into play (A. Clarke, Ngāi Tahu, Māori midwife).

Māori can feel marginalised

The small number of Māori students enrolled in midwifery in the main centres and via satellite programmes, often with no Māori staff members, can be daunting and can intensify feelings of loneliness, as a student explains:

...where are the Māori faces? It can't be hard to get a Māori lecturer. They don't have to just talk about Māori stuff. Normalise it, normalise being Māori (P. Nei, Ngāi Tahu, Māori midwife).

For this student, the lack of Māori lecturers in her programme made Māori midwives the exception, heightening her feeling of being a minority within midwifery. Māori knowledge and expertise are frequently ignored or contested, which in turn makes Māori feel unworthy or invalid and sometimes invisible. This disregard of Māori expertise seems to contrast with government policies that called for more genuine recognition and inclusion of Māori knowledge and perspectives (McCarthy, 2019).

Last year we had a workshop, and it was 1-2 days out at Ōtākou. That was like a Treaty of Waitangi workshop, and we stayed at the Marae. I did feel like there could have been more, and although we had the hauora paper, I don't think it offered that much insight besides the Treaty of Waitangi. In my second year, we don't particularly have a Māori paper; we had the Tūranga Kaupapa workshop... which was great. As for my peers, although they read the meaning of the words (in Tūranga Kaupapa) they didn't really understand it. I do think there is room to add more (Māori content) into the current midwifery curriculum (D. Gibbs, Ngāi Tahu, Māori midwifery student).

This student raised a number of points in her response. She highlighted the lack of time and curriculum content allocated to hauora Māori and mātauranga Māori in her midwifery training. There seemed only to be teachings on the Tiriti o Waitangi during their Marea nohonga (Marae stay), which was well received but not continued in the rest of the learning. Bishop (2009) stated that educational disparities are created by educational policies and practices being developed within a colonial framework that perpetuate the lens of the culture of the author. The inclusion of mātauranga Māori into the midwifery curriculum beyond the Tiriti o Waitangi seems to be met with resistance. A colonial framework still remains within our larger educational bodies that limit how much Māori knowledge can or cannot be included. Scheurich and Young (1997)

describe this kind of situation as embedded racism that “reflect(s) and reinforce(s) social history and the controlling position of the dominant racial group and that this has a negative result for people of colour in general” (p.13). Māori researchers and education experts, such as Smith (1997), Irwin (1992) and Bishop (2005), have asserted that, rather than seeking solutions to Māori feeling marginalised in education from the dominant culture, the answers may lie more localised within Māori cultural ways of knowing (mātauranga Māori) (Bishop, 2009).

One midwifery student said that even with the hauora (Māori health) paper in her midwifery programme, she heard discussions that challenged why students needed to learn Māori and why not other cultures. The student agreed that it would be good to include knowledge about other cultural birthing practices, but she felt that many of the students did not understand the concept of a bicultural nation until they had completed the Treaty of Waitangi paper during the course. The teaching in this paper far outshone the education most had received at school about the Treaty of Waitangi and was life-changing for several students, she believed (T. Stone, Ngāi Tahu, Māori midwifery student).

Holding on to tauira Māori (Māori students)

The attrition rates for Māori midwifery students are high. Māori students are more likely to leave in their first year of studies. A sense of not belonging or not being exposed to others like themselves is one of the possible contributors to a student’s decision to leave midwifery. Additionally Māori receiving their midwifery tuition remotely and struggling with the lack of interaction, especially the face-to-face contact (Fleming, 2014). Other Māori midwifery students realised that the commitments are far greater than they first thought, for example, a lecturer described a student who left after three months of study. While the student was enjoying the process of providing continuity of care to the women she was working with and recognised the importance of professional commitment, she acknowledged that her tamariki were not getting a continuity of mothering and reported she would come back when she is available to provide that (A. Day, Midwifery lecturer).

In 2015, a Christchurch midwifery education provider had six Māori students graduate out of a class, and in 2016 they had three. Two-thirds of their Māori students come through a six-month bridging course, called the *NZ Certificate in Study and Career Preparation (Health)*, developed within the Polytechnic and designed to encourage more Māori students into health careers. The course intentionally runs with smaller and more intimate groups to facilitate bonding and keep students feeling supported and less likely to drop out. The midwifery lecturers interviewed for this study also concurred that bridging programmes such as these better prepare students for the requirements of the midwifery degree. They also felt that it is an excellent avenue for Māori to initially pursue because crucial student bonding occurs and it is proving to be a successful step towards reducing Māori midwifery student attrition rates once they commence the midwifery degree,

Most of the Māori students come through the pre-health certificate programme and they seem better prepared for the requirements of the programme, it provides a good bonding experience (A. Day & S. Pit, Midwifery Lecturers).

In Dunedin's midwifery course in 2016, there were two Māori students out of a class of 20 and approximately 8-10 Māori students from all the Otago Polytechnic satellite classes and main campus from a total of 60 students (D. Gibbs, Ngāi Tahu, Māori midwifery student). The importance of making strong connections among peers as soon as possible appears to be crucial in keeping Māori in training.

The financial demand on midwifery students was highlighted by two of the research participants as a deterrent to entering the training. They reiterated that the cost of the course, especially for students with tamariki, added another layer of stress that may have contributed to the decisions of their student peers to leave the programme.

We pay for our travel and we pay for all of our fuel. Then you have clients in the community, and last year I had clients in Mosgiel (15km out of Dunedin). I had appointments every week in Mosgiel. In the first weeks, we would visit them every day, so there's the fuel cost and a time cost. There's no financial assistance for that (D. Gibb, Ngāi Tahu, Māori midwifery student).

Commitment to the course and practicums are demanding on students, more so for those with families and cultural obligations. The coursework can be challenging as students undertake a 45-week programme. A typical degree programme in New Zealand is 36 weeks per year. Having the degree completed in three years instead of four does provide benefits, such as not having to pay another year of enrolment fees and completion is quicker, yet the intensity is heightened as agreed by most of the research participants. To grow a sufficient and supportive Māori midwife cohort, they must be trained in greater numbers across all four midwifery training establishments in Dunedin, Christchurch, Hamilton, and Auckland. While some Māori are taking up midwifery as a career choice, the Māori midwives who took part in this research claimed that Māori are not doing so at a rate that appears to be meeting the needs of our growing whānau Māori, nor at a rate that will sustain a robust network of Māori midwifery professionals (A. Clarke, Ngāi Tahu, Māori midwife; R. Chisolm, Ngāti Porou, Māori midwife; Tikao, 2013).

Cultural and whānau commitments outside of study take up a lot of time and energy, and this was acknowledged as a potential barrier to Māori midwifery students completing their midwifery training. Being away from the whānau during the period of the degree can also be too hard for some Māori students (Midwifery lecturers; Chisolm, Ngāti Porou, Māori midwife; Clarke, Ngāi Tahu, Māori midwife and Educator; Te Huia, Ngāti Kahungunu, Māori midwife). The midwifery lecturers involved in this research shared that at least 50 percent of their Māori students are parents. The reason given by many Māori students who are unable to complete the course is the realisation that the degree can be overwhelming and the juggling between whānau and student life becoming too hard to sustain.

Māori society is a collective kinship of whānau, hapū and iwi groupings. Māori will often view themselves as a representative of their wider whānau; this entails meeting whānau and/or Rūnanga (Ngāi Tahu term for a sub-tribe's governing body) obligations, be it to a planned marae event to assist or take part in, or to an unplanned tangihanga (funeral). Regardless of the occasion, whānau and hapū obligations do impact upon study commitments and can lead to students feeling that the manipulation between cultural responsibilities and their studies was too difficult (J. Te Huia, Ngāti Kahungunu, Māori midwife).

Prioritising mātauranga Māori

A comment raised by informants from both South Island midwifery degree institutes, is that the squeeze of the four-year degree into three years makes it difficult to add more knowledge content into an already crammed curriculum. But it still begs the question of what the institutes and the heads of the midwifery schools believe is priority knowledge and what they are prepared to adjust, combine and have less of in order to prioritise Māori birthing knowledge.

Sally Pairman (Personal Communication, October 2016) Chief Executive of the International Confederation of Midwives (ICM) and founding member and ex-President of the New Zealand College of Midwives, was asked as a research participant whether more Māori knowledge pertaining to pregnancy and birth can be included into the current Bachelor or Midwifery curriculum. Pairman explained that the issue is not about the content but the amount already in the curriculum. She clarified that the bigger problem they have is getting the midwifery students enough practical experience, and this overshadows extra tuition on specialist subjects. Pairman admitted that the current midwifery degree struggles with fitting all subjects in the curriculum, especially when you have 4800 hours, and approximately half of those hours are practical, leaving the other 2400 for theory and midwifery content. She felt, however, that she could still, within the current curriculum, develop cultural safety skills with the midwifery students to better improve the way they work with women and the woman's whānau. This included taking the whānau's lead on matters of importance and having excellent clinical skills. Pairman thought improving students' skills was more achievable with the same outcome, an understanding and empathetic approach to work with wāhine and their whānau that reflects the desires of the individual whānau. Pairman said the midwifery degree focusses on who the pregnant women are and what their needs are, what is essential to her, inclusive of her culture, and how they as midwives can enable these needs to be met.

I don't think I could ever be an expert in traditional Māori birthing practices, and who is? So, what's my role then as a midwife? Well, my role is, if I have a woman who is Māori or any women actually, any woman who wants things to

happen at her birth that are important to her, that are going to make her feel safe and make this whatever it is, this celebration, this acknowledgement... how do I just facilitate and help there and not get in the way of it? ... That's what we are we're trying to teach with the students, and I think that that is actually cultural safety... It's just being open, not making a judgement, not coming with stuff or at least understanding if you have got stuff, what it is and how not to let that get in the way (Pairman, 2016).

Pairman (2016) sees the midwife as a facilitator, someone who is open rather than someone who has to know everything about cultural practices. The difficulty with this stance, however, is that there is already a lack of Māori knowledge taught within the midwifery curriculum and the midwifery lecturers interviewed for this research have witnessed ignorance in some of the mature midwifery students concerning New Zealand's founding document, Tiriti o Waitangi signed in 1840 between the Crown and Māori. Therefore, Pairman's comment could be interpreted as an excuse that avoids advancing midwifery students' knowledge of poignant New Zealand history in the hope that they will remain open and supportive of cultural matters in the future.

At least four New Zealand Health strategies, namely the New Zealand Disability Strategy 2016, Māori Health Strategy 2014, The Royal Commission on Social Policy 1988 and the New Zealand Health Strategy 2016, identified principles that are derived from the Tiriti o Waitangi that are relevant to Māori health and play a part in improving health outcomes for Māori. One of those principles is protection, and this entails safeguarding Māori cultural concepts, values, and practices. Health should be seen as a taonga that is protected and retained under Article II in Te Tiriti o Waitangi (and the English version The Treaty of Waitangi). Pairman has applied a caring and open response to working with all pregnant women wanting specific (cultural) practices in their birthing plans. The concern is that Māori get swept under the carpet of treating everyone the same when our health statistics beg for a different approach from our health practitioners. Māori babies die more frequently from sudden infant death syndrome, Māori have low birth weights compared to non-Māori and Māori women have had persistently weak statistics in breast, cervical and lung cancer (MOH, 2019).

Overall, Māori have higher incidences of obesity (27 percent compared to non-Māori with 16 percent); this directly adds to the high incidences of diabetes (eight percent for

Māori and three percent for non-Māori). The outcome of poor health status for Māori is that we are dying of avoidable deaths at twice the rate of other New Zealanders and eight to ten years younger (MOH, 2019). Training health practitioners to correctly attend to Māori clients in a culturally responsive way, to build rapport, trust, and an effective health relationship, does matter and does make a huge difference to the outcome of not only that client but to their whānau (Mauri Ora Associates, 2008).

Defining cultural safety

Over the history of midwifery education, the shaping of midwifery pedagogy appears to have had very little Māori influence until the 1990s. The late doctor Irihapeti Ramsden trained as a registered general and obstetric nurse and worked for many years at Wellington Hospital. She critiqued the nursing practices of the time, especially concerning cultural safety, and encouraged further Māori knowledge to be incorporated within nursing and later midwifery professional competencies. Ramsden summarises her thoughts about the importance of cultural safety in the following passage (1990). Sadly, her views remain relevant almost 30 years later.

The data on Māori mortality and morbidity and practical experience has made it quite clear that many of our people have voted with their feet when it comes to the health service. The health service is not and has not ever been culturally safe for Māori people. It has never been affordable for people whom history has forced into poverty... The (health) service has not been designed to fit the people, the people have been required to fit the service... as long as Māori people perceive the health service as alien and not meeting our needs in service, treatment, or attitude, it is culturally unsafe... The vital importance of physical safety in nursing of other human beings is equally acknowledged by Māori nurses. The same level of importance of ethical and of legal safety is also acknowledged. The Tangata Whenua have added a further criterion to safe service delivery, that of Kawa Whakaruruhau, Cultural Safety (Ramsden, 1990, p 3).

Ramsden's doctoral work and indeed many years of nursing and personal experience helped her write her thesis, titled *Cultural safety and nursing education in Aotearoa and Te Waipounamu*. Ramsden acknowledged that a hui held in Christchurch in 1988, sponsored by the Ministry of Education, was the beginning of an educational

framework that became synonymous with cultural safety. This framework was highly influential in both nursing and midwifery education and professional practice and remains in place today. At this seedling hui, Māori nursing students discussed their cultural safety within nursing training and why the training was not providing the skills and knowledge to best prepare them to provide culturally safe services for their patients. The hui resulted in a clear direction to the education organisations to provide more education to their tutors about New Zealand's colonial history to be resourced adequately to teach their nursing students. It was the first step towards activating cultural safety for Māori students.

The Midwifery Council credited Ramsden's Kawa Whakaruruhau work for helping to shape and define the Council's Midwifery Partnership as the quintessence of midwifery practice. Between 2004 and 2007, the Midwifery Council utilised the *Nursing Council Guidelines for Cultural Safety* developed by Ramsden before the adoption of *Tūranga Kaupapa (Māori values encapsulated in cultural guidelines for midwifery practice)* in 2007 (Ramsden, 1996, 2002; Wepa, 2005). Kawa Whakaruruhau is embedded into the cultural competency framework amongst other competencies required to become a registered midwife. The Midwifery Council of New Zealand's cultural safety guidelines state that effective midwifery care starts with midwives who are aware of their own cultural identity and how this impacts their practice. Midwives who epitomise cultural safety are those that address inequality and inequities within their professional relationships and health care services. This is to gain a harmonious power base between users of midwifery services and those delivering the service (Nursing Council of New Zealand, 2005, 2011; Pairman & Donnellan-Fernandez, 2010; Ramsden, 2002).

Ten years post-Ramsden's formal introduction of Kawa Whakaruruhau, a call by a close friend and colleague Michelle Edwards, former Nursing Council consultant and current clinical team leader at Te Piki Oranga Māori Health and Social Services in Nelson, reminded Māori health professionals not to forget the hard work and the significance of the late Irihapeti Ramsden's work on cultural safety in our professions. Edwards said that Kawa Whakaruruhau runs the risk of being identified within a Pākehā culture, and she challenged Māori health professionals to be kaitiaki (guardians) of the Kawa Whakaruruhau framework to ensure as Māori that it remains intact and used how Irihapeti intended it, and not dissected and redirected to fit mainstream teaching (Kai Tiaki, 2017, p. 29).

Tūranga Kaupapa

Following Ramsden's immense contribution to both the nursing and midwifery curriculum, another opportunity for cultural inclusion into midwifery education arose. Ex-president of Ngā Maia Māori Midwives Aotearoa (National Māori Midwives Organisation) Jean Te Huia explained that Henare Kani, alongside his wife and practicing midwife, Tunani, wrote Tūranga Kaupapa for Ngā Maia Māori Midwives Aotearoa. Tūranga Kaupapa is a programme designed to provide more midwifery guidance specific to Māori values and cultural practices for Māori women during pregnancy and childbirth. The Tūranga Kaupapa principles were adopted by the New Zealand College of Midwives in 2006 and incorporated into the Midwifery Council of New Zealand's *Cultural Guidelines for Midwifery*, as a pre-registration standard in midwifery education in 2007. Alongside Kawa Whakaruruhau, Tūranga Kaupapa strengthens the focus and intent for cultural safety for practicing midwives (Midwifery Council of New Zealand, 2007).

However, like Kawa Whakaruruhau, the accountability to prioritising Tūranga Kaupapa in midwifery education and how it has been received by midwifery students and midwives around New Zealand differs. Over the last two years, Kani has further developed the Tūranga Kaupapa programme into a cohesive and thorough teaching package. It can be adapted to be hapū specific and now includes a national team of Tūranga Kaupapa facilitators to deliver the programme to midwifery students and midwives. As a stand-alone programme, Tūranga Kaupapa has developed through the determination of the authors, Ngā Maia Māori Midwives and with support from the New Zealand College of Midwives. However, the Tūranga Kaupapa authors and Ngā Maia Māori Midwives concur that more mātauranga Māori still needs to be integrated in the midwifery curriculum with greater depth to include customary Māori maternity knowledge and narratives (Kani, 2017).

Reaching out for whānaungatanga

The Māori midwifery students participating in this research expressed the paramount importance of whānaungatanga. Relationships matter and these relationships include whānau, their peers, their lecturers and other Māori midwives. The Māori midwifery students in the South Island were eager to have their practicums in Māori communities under the leadership of Māori midwives.

For third year, I was really hoping to try and get in with some Māori midwives. I've considered trying to go all the way up to Hokianga for a placement. I've been limited in Dunedin with Māori midwives because there isn't actually one that identifies as being Māori in our community, which is hard (D. Gibbs, Ngāi Tahu, Māori midwifery student).

The desire of some Māori midwifery students to head out of Dunedin or Christchurch to Northern Māori communities to work under more Māori midwives and to grow their midwifery skills can be confronting. Gaining the respect and acceptance from these communities is principally about whānaungatanga.

I went to Kaitaia (for my practicum) and I had two kuia turn up and they only spoke Māori to me. They asked me why I chose Kaitaia, they had to find a connection with me. I told them that my grandfather was from there... when I was growing-up he took me everywhere. When they realised that I was actually related to them they felt way more comfortable. It's much more than just midwifery (T. Stone, Ngāi Tahu, Māori midwifery student).

These comments also highlight how important it seemed to the Māori midwifery students to see themselves in others by actively seeking Māori midwives and Māori communities to feel “themselves”. The “midwifery partnership” is NZCOM’s example of whanaungatanga. This concept came from NZCOM’s directive to move away from the traditional perspective of the health professional being more powerful than those seeking their services. Therefore, the power shift went from the midwife to the pregnant mother to allow the mother to have more control over her own birthing experience (Gulliland & Pairman, 1995; Pairman, 2005). Although the midwifery partnership model has adapted as the maternity environment has evolved, the fundamental relationship between the midwife and the mother during the birthing experience has remained constant (Pairman, 1999). MCNZ believes that “a culturally competent

midwife integrates midwifery partnership, cultural safety, and Tūranga Kaupapa into her practice” (Pitcombe et al., 2015, p. 386, Midwifery Council of New Zealand, 2003).

The inclusion of Ngāi Tahu customary birthing knowledge

When considering the future of midwifery education and how Māori knowledge can be further incorporated into the midwifery curriculum, research participants had mixed responses. The midwifery students from two different midwifery schools affirmed that they would like to see more Māori birthing knowledge provided in their midwifery training. Students currently receive an introduction to cultural relationships in a historical capacity. However, there is still a desire from Māori students to learn more about Māori customary birthing practices and how they can implement these practices and tikanga into their delivery of care.

I really love the idea (of a traditional Māori birthing paper within the current BA Midwifery), had that been available to me in my first year I could have carried it through. It’s quite a big paper, so it’s better as a post graduate paper. The problem though, is there is not a lot of midwives who do post-grad papers because they are working all the time, so I don’t know if people would pick that up? (P. Nei, Ngāi Tahu, Māori midwife).

A Māori midwifery student felt it would be better to include more Māori customary birthing knowledge into the current curriculum but felt this responsibility of learning was hers to seek once she had completed her midwifery degree.

I can go out there and say I am a Māori midwife, but I think for me to be able to offer Māori what I want to offer them, that’ll be my own learning, it’ll be self-directed. I’m going to have to do my own research into that... I don’t know if I will get there in the next year and half (by the time she finishes her degree). I think that’ll be more like a lifelong learning experience, to be able to deliver that to women (D. Gibbs, Ngāi Tahu, Māori midwifery student).

A Māori midwifery student and midwife felt that they would have jumped at the opportunity to learn Māori birthing knowledge and customs during their training. However, upon further pondering, they decided it could work better as a body of knowledge within postgraduate papers.

Perhaps there could be a particular six months intensive for an added component (to the Midwifery Degree) that could be open to anyone. Encourage Māori, obviously, but it could be open to anybody who wanted to add that to their string. Find a way of providing a six-month intensive on cultural birthing practices, and I think you will have a huge change in everything (P. Nei, Ngāi Tahu, Māori midwife).

Both these participants acknowledged that sustaining the interest from Māori midwives could be problematic. One Māori midwife felt that midwives would be extremely interested in a six-month intensive. However, she also reflected that the long hours of midwifery work and lack of energy might deter them from taking up this endeavor.

A midwifery lecturer claimed that their programme integrates Māori knowledge throughout their midwifery curriculum. The midwifery degree begins with a *whakawhanaungatanga* (relationship building) process. Students are placed into groups to build support systems further. *Kaiako* Māori (teachers) or *Pākehā kaiako* are set with this group to enhance the *tautoko* (support) further. The *rōpū tauira* (Māori student group) is also linked early in their study with the Canterbury Midwifery Rōpū (Canterbury Māori Midwives Collective). Māori models of health are utilised throughout the midwifery subjects endeavouring to integrate Māori knowledge and perspectives. The programme facilitates annual *nohonga* (intense learning sessions held at the Marae) at one of the local Marae in the first term for the first-year students. This is felt to lay a bicultural foundation that the midwifery school aims to uphold throughout the degree. *Tūranga Kaupapa* (Māori midwifery competencies) is taught in the second year and students learn and can discuss the *Tiriti o Waitangi* in-depth in the *Hauora Māori* paper, which includes a brief overview of creation mythology, Māori birthing practices and the statistics on Māori health from historical times to the present (A. Day & S. Pitt, Midwifery lecturers).

Midwifery lecturers support the concept of a post-graduate paper in traditional Māori birthing practices, as they feel that what they are trying to achieve in the Bachelor programme is a Māori foundation with an “openness of heart and mind”. Having an opportunity to extend this knowledge for some students would be advantageous, and the lecturers could foresee the benefit of this. However, the overall feeling was that this

would be a difficult addition to the Bachelor programme given the lack of Māori staff and time to cover the current four-years-in-three curriculum (S. Pitt, Midwifery lecturer).

Another midwifery lecturer felt that because of the diversity of student backgrounds, demographics, understanding of te reo Māori and life experience, it was perhaps too difficult to teach more mātauranga Māori (Māori knowledge) into the current curriculum for first and second-year students but was possibly an option in their third year. However, she pondered over the success of the implementation, given the intensity of the degree as it currently stands.

I acknowledge that for some students it is not their reality, it's never been their reality, they're not Māori, some of them are tauiwi (not Māori) from overseas, and although they are open to it and many have not heard anything about Māori before, some are 18 and some are over 35. The Māori content can be an enormous concept for them to grasp, and I am unsure how to manage it. I also find it difficult when I have tāngata whenua in the classroom who have been raised with this knowledge (R. House, Midwifery lecturer).

Some midwifery lecturers described the struggle to deliver the Māori content to an already diverse cultural cohort of midwifery students who vary in ages and prior knowledge on Māori culture. The thought of including more in-depth mātauranga Māori pertaining to maternity can be daunting for those teaching it. Another concern raised by midwifery lecturers, is insufficient time and weight given to a topic which may be more harmful than leaving it out altogether. One lecturer warned that an element of tūpato (carefulness) was needed around the implementation of Māori maternity knowledge to ensure it is done credibly, with students understanding the content, appropriateness, and practical application of what they had been taught. Students and lecturers, she argued, would better receive an implementation of traditional Māori birthing practices and rituals into the current midwifery curriculum if thorough planning and guidelines had been undertaken prior to their introduction. Time to cement the additional mātauranga Māori would also be needed to embed it into the entire midwifery programme better.

Midwifery lecturers at another midwifery school felt that it was imperative to include Māori customary birthing knowledge into their teaching across the curriculum, which they thought they had started to do. However, they did acknowledge (like the lecturer above) that the mature students entering into midwifery school with varied life experiences often had very little integration of the Tiriti o Waitangi into their personal or working lives and could feel confronted by this at tertiary level learning. These lecturers commented that the younger students have already been exposed to Tiriti o Waitangi teaching in their schooling, so they were less opposed to the incorporation of Tiriti o Waitangi issues and the integration of Māori kaupapa (topics) within their maternity training. All lecturers agreed that prior knowledge of the Tiriti o Waitangi and how it impacts people's professional lives does make teaching issues of Māori traditional knowledge less contentious.

More Māori educators needed

Building the capacity of lecturers, Māori and non-Māori, to teach mātauranga Māori and Māori maternity health remains a challenge. One midwifery lecturer said she lacked confidence and cultural support to develop the cultural content because she was not Māori, and this made her question whether she should be producing this teaching material:

When I was working on the scope of midwifery practice, I wanted to create an authentic scenario that was bicultural and acknowledging practices, but I was feeling quite shy and unsure about how far to go and whom to share this with, and what's my knowledge to share, even the use of images and copyright, I was unsure about. It feels like there is so much we can do but end up pulling back because is it our place to use it? (S. Pitt, Midwifery lecturer).

There appears to be a lack of cultural support onsite within the Bachelor of Midwifery programmes in the South Island, and both the midwives and the Māori midwifery students seem very eager to have more ongoing engagement with Māori expertise.

I'd like someone to walk alongside me in that planning, and then I would feel more confident that yes, this is the right thing to do (S. Pitt, Midwifery lecturer).

Although one Māori midwifery lecturer said she was deeply passionate about the kaupapa, she acknowledged that having the skills to teach it was beyond her current skill level. She also expressed fear of teaching something she felt was quite powerful that could potentially become compartmentalised and misinterpreted. She was also apprehensive that, if taught poorly, ultimately, a midwife could potentially give someone a bad birthing experience through their naivety of the depth of the cultural practices and how to deliver them safely within the professional practice boundaries and capabilities.

I just would worry about someone taking a little bit of something and putting it in the wrong context. I'd be mortified if I delivered or co-delivered something and then I heard five years later that someone had a really terrible birthing experience because someone thought that they could do a birthing karakia and it was wrong or inappropriate (A. Day, Midwifery lecturer).

Many Māori midwives do not appear confident taking on the role of being a lecturer and need a lot of affirmation by their midwifery peers that they possess the skills to hold such a role. One Māori midwife said she was quite taken aback by exceptionally well-educated and experienced Māori midwives feeling apprehensive about their abilities in a tutoring role within the midwifery schools (R. Chisholm, Ngāti Porou, Māori midwife). A. Clarke (Ngāi Tahu), an ex-Māori midwifery lecturer shared that when she was working on the Māori component of the midwifery curriculum, she felt proud of what they had managed to produce alongside her academic peers.

We were a blended delivery. It was really interesting in relation to that. We integrated it initially by introducing a noho Marae. It was a way of committing them to the whare itself, then to the value systems in quite a gentle way... that occurred at the beginning of the course. It was really about those resistors, potentially because they are just a subset of the wider community to feel what it was to be in a Māori world (A. Clarke, Ngāi Tahu. Māori midwife).

Each Midwifery School appeared to approach Māori knowledge within their curriculum differently. In the case of Ara, their Māori tutors wrote and delivered a large part of their Māori-focused papers. Clarke (2016) introduced Māori knowledge around the concept of “What is culture, what is identity?” The students were then led to further discussions around identity and how it is constructed for Indigenous peoples and specifically for Māori. A key goal for Amber was to embed Māori into the midwifery

curriculum, starting with creation stories and then to ensure that Māori knowledge was woven throughout the curriculum. For instance, on the topic of breastfeeding, the concept of ūkaipō (breastfeeding at night, place of nurture, home) was also addressed at this time from a Māori worldview (Clarke, Ngāi Tahu, Māori midwife).

Overall, we need more Māori midwifery students coming through midwifery schools and ideally through the two Te Waipounamu providers (ARA and Otago Polytechnics) that sit within the Ngāi Tahu takiwā (tribal boundary). An active recruitment process is required, targeting Ngāi Tahu members to consider midwifery as a career. Offering incentives in the form of midwifery scholarships that are inclusive of travel costs while on practicum. Scholarships that acknowledge how difficult it is to seek part-time employment during the long hours of practicum, and adequate child support to allow mums and single mums studying midwifery to do practicum without the concern of childcare expenses. What we have learned from the past, is that Māori utilised the tuakana-teina model of recruitment by having a protégé work alongside the tuakana and learn as they work. This is currently happening to some extent with Māori midwifery students assigned to Māori midwives as mentors, if available, but I believe this practice needs to be taken to the High Schools and Whare Kura. The aim would be to attract senior secondary students to work alongside midwives to commence the learning at this age and stage for greater uptake in midwifery training at tertiary level.

My master's research identified that there appeared to be a dilemma for Māori midwives to be acknowledged as Māori midwives, as the weight of this description was too much for some participants to carry. They felt that with this title they should be able to speak te reo Māori and be able to offer whānau Māori traditional birthing knowledge and be confident with traditional Māori birthing resources when they were not equipped to do so. Others felt they were still learning their taha Māori (Māori ancestry) and felt too whakamā (shy) to be able to offer this to their patients (Tikao, 2013).

Cultural support through my training and career made the difference.

A Māori midwife and leader for many years of the Canterbury Māori Midwifery Rōpū said that one of the reasons for the establishment of the Canterbury Māori Midwifery group was to provide support and networking for Māori midwifery students. To have regular gatherings and the ability to buddy student midwives with Māori midwives in an attempt to bring comfort to those Māori who may grapple with being away from their whānau whānui (extended family), as discussed previously (R. Chisolm, Ngāti Porou, Māori midwife). Hence, the need for support groups within the midwifery school and the community is essential in the retention of Māori midwifery students through to degree completion. An experienced Māori midwife was concerned that Māori students were not prepared for tertiary studies:

I think the majority that leave the course for whatever reason that's not academia, it is usually whānau demands... They are capable academically and we have to nurture them. I remember a taua saying that if we can get any of our Māori students in there (studying for their degree in Midwifery), it is the role of their tertiary institute to get them out on the other side, whether it's three or ten years. It is their responsibility (R. Chisolm, Ngāti Porou, Māori midwife).

Another initiative is the Midwifery First Year of Practice Programme (MFYP). It is a compulsory programme for all new midwifery graduates and provides professional support. MFYP cements the midwifery training with a midwifery practice; it also appears to be successful at keeping new midwives in practice longer (Kai Tiaki Nursing New Zealand, 2016).

New Graduate Mentoring

Transitioning from student to newly qualified midwife can be overwhelming and demanding. Adapting to what is required in their new midwifery role and often a new workplace can leave graduate midwives feeling unable to make decisions about clinical assessments due to a lack of confidence and experience (Pairman et al., 2016). It has been acknowledged internationally that health professionals need additional support; the introduction of transition programmes bridges the gap and assists with confidence, consolidating knowledge and being able to reflect upon clinical scenarios to deepen their midwifery knowledge base (Pairman et al., 2016).

The Midwifery First Year of Practice programme (MFYP) was introduced in 2007 to support new graduate midwives during their first year of practice regardless of their place of work. The programme has designed to be flexible to meet the needs of the student, whether they had chosen to work in the community, case-loading women or in the hospitals (New Zealand College of Midwives, 2000). MFYP is a structured programme that includes clinical support, a funded midwife mentor, and education assistance. The education component requires participants to attend compulsory workshops and elective education opportunities. Midwifery graduates are required to do an assessment and an evaluation process at the end of their first year.

One of the critical intentions of the MFYP programme was to retain midwives in their practice setting for longer (Dixon et al., 2015). An evaluation of the MFYP programme between 2007 and 2010, which involved 415 midwives who graduated from a New Zealand midwifery programme, highlighted that MFYP was successful in retaining new graduates in the profession. Of the 415 who completed the evaluation, 10 percent identified as Māori (Dixon et al., 2015). The findings from the evaluation found that the outcome for the MFYP programme was high retention of midwifery graduates on a national level following the completion of the programme.

The evaluation revealed that, over the five years of study, the graduates were getting younger; this is also reflected in the reports from the New Zealand Schools of Midwifery. This is an interesting trend change for the profession. As stated, prior, the average age of midwives in New Zealand is 47 to 48 years of age, with a trend now heading towards a younger midwifery cohort of around late 20s to mid-30s. The benefit of a younger group of professionals, is the number of years they may be able to give the profession, growing more experience and knowledge throughout their careers (Midwifery Council of New Zealand, 2010a, 2010b).

The MFYP programme is one strategy to improve the retention of new midwifery graduates in the workforce and assist in strengthening clinical decision-making (Brown, 2015). The enhancements to the programme in 2015 and 2016 addressed criticism that new midwifery graduates were picking up bad habits and needed to experience different clinical settings with a variety of midwives who have different approaches to safe midwifery practices (Brown, 2015). The Wellington Women's Health Research Centre

also conducted research that matched the level of midwifery experience to baby mortality data. The results showed that the new graduate midwives with only one year's experience had a higher likelihood of a baby dying at birth under their care (Coleman, 2016). The evaluation of the MFYP programme highlighted that Māori graduates were remaining in the midwifery profession longer than previously (Dixon et al., 2015). In 2015, MFYP was made mandatory for all midwifery graduates and appeared to be a successful and positive new graduate programme in maintaining a high standard of midwifery care in New Zealand (Kai Tiaki Nursing New Zealand, 2016, p. 9).

A key finding from a New Zealand research project that explored the midwifery perspective of the MFYP between 2007-2010, was the invaluable role of mentoring and connection to the broader midwifery community. This support was viewed as vital in their successful transition from new graduate to the professional midwife. Pairman et al. (2016) claimed a noticeable difference between previous evaluations of transitional programmes; their more recent research on collective responsibility for supporting new graduates is evidence of a complete culture change within midwifery which appears to have occurred within the last decade. This change has been directly linked to the positive impact of MFYP on new graduate midwives (Pariman et al., 2016).

Kupu Whakarāpopoto (Summary)

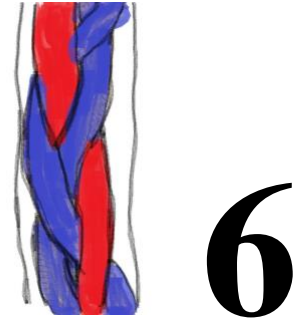
To conclude, the themes raised in the data highlight that Māori students and Māori midwives are feeling marginalised within their midwifery training and midwifery profession in the South Island. They seem like lone voices advocating for more kaupapa Māori within the curriculum and the desire for more Māori colleagues in the profession to navigate the Māori midwifery pathway together. The networks that have been established are those that Māori midwives have forged themselves with minimal funding and modest professional recognition. The desire is definitely there from the Māori midwifery students and midwives participating in this research to learn more about traditional Māori birthing practices alongside te reo me tikanga Māori, done in a supportive and flexible way. Until more Māori midwives feel confident, competent and supported by their education institutes and the midwifery professional bodies, they will remain marginalised, and the task of cultural growth in maternity will continue to be too hard.

The current climate of the midwifery profession poses another set of challenges. The midwifery workforce is on the decline due to poor working conditions and low pay, particularly in rural areas. This incremental decline in practicing midwives who are opting to work part-time is also reflected in smaller numbers of midwives graduating with their Bachelor of Midwifery degree and fewer qualified midwives coming from abroad and entering our workforce (NZ College of Midwifery, 2019). A shrinking workforce could be seen as a major barrier in the request for more kaupapa Māori in the training and professional development of midwives. Yet, on the contrary, this is the time to bring dynamic improvement to the teaching of midwifery and offering to whānau katoa (all families) a unique New Zealand birthing experience. More Māori historical knowledge about Māori health and maternity practices is advantageous in the Bachelor of Midwifery degree. This may also lure more Māori to the degree, which will then meet the inevitable demand upon the maternity sector from a growing Māori population with a stronger cohort of culturally aware young women. They will be campaigning for the provision of more kaupapa Māori in their birthing plans and greater access to Māori midwives.

This chapter acknowledges there have been, and still are, many legends within New Zealand's midwifery profession who have bravely fought hard to advocate, develop and nurture the midwifery workforce, sometimes in contestable environments where midwives have had to hold on to their autonomy. Māori midwives have also had to endure challenges, and their experiences add a vital strand to the overall narrative. The late Kukupa Tirikatene summarised the importance of all individual threads contributing to this knowledge base in his whakatauākī (proverb):

Kore e taea e te whenu kotahi ki te raranga i te whāriki kia mohio tātou ki a tātou –
The tapestry of understanding cannot be woven by one strand alone (Personal Communication, 2010).

This whakatauākī can also imply that one strand cannot dominate others and that the other strands of knowledge and thought need to be included and honoured. Collectively, the many strands will make something more durable, robust, and unique to that collective. I liken this to a whāriki (woven mat) that has been woven with all the information from previous chapters. This whāriki is now laid down to spiritually receive the following chapter. Chapter six delves deeper into specific Ngāi Tahu birthing traditions, and why I believe renaissance of this particular kaupapa will make a significant difference to the hauora and mauri of Ngāi Tahu in the coming years; and why the of mātauranga by curriculum creators will only enhance the current Bachelor of Midwifery degree.



Whānau Mai / Ngāi Tahu Traditional Birthing Practices

E Rongo ki wahi matatahi mai te ara o
tūmau uhuri tuarangi

Ko te Tīmatatanga (Introduction)

The previous chapters have set the historical and contemporary maternity scene in preparation for this chapter highlighting Māori and Ngāi Tahu repositories of customary birthing knowledge. Exploring Ngāi Tahu birthing traditions has led to an inquiry into birthing rituals. Vital cultural knowledge can be lost if rituals are no longer conducted or even deemed necessary. This is due to dominant Western maternity practices and medicines now entrenched into the psyche of many members of Ngāi Tahu (Barlow, 1991; Marsden, 2003).

Kaupapa Māori research can be a powerful decolonising tool that can begin to remove the colonial shackles of assimilation, in order for Māori to feel confident and empowered by customary practices, such as birthing tikanga (Lavalley, 2009; Smith, 2002). Researching Māori and, in particular, Ngāi Tahu mātauranga (knowledge) requires broadening the research approach and exploring the many ways in which a tribe articulates and archives their knowledge. Therefore, pūrakau (stories), mahi toi (art works), and whenua me te taiao (land and the environment) alongside the physical

and spiritual pathways are all important sources of knowledge, and how Māori applied and amended their knowledge.

Traditional knowledge that has been passed down the generations, and spiritual knowledge that comes from the spirit world are often expressed in dreams, visions and stories. It is a common acceptance amongst Indigenous cultures that the physical and non-physical realms are real. Indigenous epistemology, according to Lavellee (2009) and Kovach (2005), encapsulates fluidity, is non-linear and is relational to the physical, emotional, spiritual, earth, sky and the universe. Indigenous epistemology according to Kovach (2005) cannot be quantified or fragmented in a Western research framework. Linda Tuhiwai Smith (2000) concurs that Māori sustain a different epistemology tradition which she suggests,

...frames the way we see the world, the way we organise ourselves in it, the questions we ask and the solutions we seek (p. 230).

Te Ahukaramū Charles Royal (2009) speaks of Indigenous epistemology as the gathering of Indigenous worldviews. Royal explains that the focus is on knowledge creation which will communally enhance relationships between humans and the natural world (p.112). He acknowledges and respects ancestral knowledge but envisages that Indigenous epistemology provides the impetus to utilise pre-existing knowledge. This drives a creative approach to knowing that recognises other epistemologies, while concurrently reflecting the present time. One could question whether Royal's eagerness to move forward incorporates a cohesive tane/wāhine perspective or is propelled more strongly by a male interest to seek and lead the evolution. Historically, evolution has not always been inclusive of wāhine Māori. In the realm of birthing practices and rituals, wāhine Māori are still in a state of return, undoing, decolonising and finding their hold in a role that has become moulded by Western practices and long-term disempowerment. Moving toward an Indigenous epistemology needs to be inclusive of understanding how women in most Indigenous communities were discriminated against to a greater extent than males. Therefore, more time is needed to understand and embrace pre-existing knowledge in order for Indigenous women to feel enabled to transform their futures.

The first section of this chapter looks at specific creation rituals conducted to: enhance fertility; obtain a specific gender; ensure the pregnancy is healthy and productive; cleanse the site where the birth took place; cleanse the pēpi and whānau; and to prepare the pēpi for its destiny (Flutey-Henare & Parata, Ngāi Tahu, Kairaranga; Tikao, 2013). Remembering these rituals for their intent and the significant role they had in ensuring the physical and spiritual wellbeing of the child and mother highlights what a significant loss we have today with so few Ngāi Tahu utilising any of these rituals and many unaware they even existed (Barlow, 1991; Marsden, 1992, 2003; Mead, 2003).

One ritual that has not been lost to the same extent as other customary practices, is the art of composing and performing waiata (songs). This artform is still flourishing today and kept alive through the many kapahaka rōpū (cultural performance groups) across a wide sector of the New Zealand community. Therefore, the second section of this chapter looks at the survival of waiata and acknowledges how the continuing passion for kapahaka (group singing) performance and competition has kept this artform active. Oriori as a genre of waiata are also discussed in this chapter, in particular: *He oriori mo Tuteremoana* written by Tuhotoariki (from Ngāi Tara); two unnamed creation waiata dictated by Teone Tikao to Herries Beattie in the 1920s; and the Ngāti Porou oriori for Hinekitāwhiti that was adapted for Tuta Nihoniho's daughter Hariata Nihoniho of Tūāhiwi (Ngāi Tahu) whakapapa and renamed *E Tapu Ra Koe*. Waiata are repositories of cultural knowledge and specific waiata provide insight into the meanings and traditions surrounding birth.

In section three of this chapter, I draw attention to another knowledge transmitter, that being toi Māori (Māori art). Artforms such as: toi ana (rock art), kōwhaiwhai (painted rafters), whakairo (carving), tukutuku (latticework), and raranga (weaving) are more than decorative adornments displayed on cave walls, within the whare tupuna (main meeting house) or other essential marae structures like the pātaka (food house). They are all message conductors, and it is the artists that scribe the information into the designs so it will never be lost (Allingham, Personal Communication, March 2016; J. York, Ngāi Tahu, Kaiwhakairo; Thompson, 1989; M. Homes, Ngāi Tahu, Rock Art; S. Eddington, Ngāi Tahu, Rock Art).

Contemporary artists, historians, and anthropologists describe Māori art as the comparative literature to the old world for cultures that predominantly base their

knowledge transmission on oratory. Particular design patterns and symbols aligned with creation can be seen across a number of Māori artforms; an example is the koru (unfolding fern frond) or spiral shape seen in whakairo (carving), tā moko (facial tattoo) and kōwhaiwhai (Allingham, Personal Communication, March, 2016; J. York, Ngāi Tahu, Kaiwhakairo; Thompson, 1989; M. Homes, Ngāi Tahu, Rock Art; S. Eddington, Ngāi Tahu, Rock Art; Heath, 2016; Neich, 1993).

Section four of this chapter highlights birthing practices, such as rongoā (Māori medicinal treatments); hinu (plant and animal oils) used as a barrier, cleanser and topically; wai (water) to labour and/or birth in, also to aid placenta removal post birth; maripi (knives) to aid the cutting of the pito (umbilical cord); and whītau muka used to tie the umbilical cord. This section also addresses locations commonly birthed in and preferred birthing positions for wāhine Ngāi Tahu (Cameron, Personal Communication, January 2011; Beattie, 1994; M. Crofts, Ngāi Tahu, kaumātua; K. Hutchings, Ngāti Porou, Te Whānau ā Āpanui, kaumātua; Solomon, Ngāi Tahu, kaumātua).

Once the pēpi (baby) has arrived in Te Ao Marama, another set of rituals take place to remove the tapu of birth, cleanse the child, present the child with a name and acknowledge the kaitiaki (caregiver) or kaiarahi (guardian) of the child (Beattie, 1994; Stirling, Ngāti Porou, Te Whānau ā Āpanui, kaumātua; Tikao, 2013; Whitau-Kean, Personal Communication, January, 2011). Waiū is the term to describe breastmilk, ūkaipo is the practice of breastfeeding, and the latter part of this chapter section addresses how breastfeeding was perceived by Māori and non-Māori up until the 1900s as an example of another forgotten Māori customary infant practice.

The final section of this chapter discusses Māori midwives remembered by participants and other kaumātua for their work and commitment to assisting whānau in the varying Ngāi Tahu kāika ([kāinga] Māori villages). The inclusion of midwives' names and stories made the research feel connected to people and places. The Māori midwives mentioned in this thesis reflect the many others who also delivered an important health service in their rohe (area) over their lifetime. Giving them space for extracts of their narratives told through the memories of others honours them and their mahi (work). Taua Meri Crofts remembers Māori midwives in the Tūāhiwi and Koukourarata area who were often called upon before the local doctors, mostly due to preference and closer proximity to the whānau in need. Other taua also share their admiration of

whānau midwives (both male and female) who, like the midwives today, were well respected for their skills and often went beyond the role of their mahi (work) to tautoko whānau in the birth of their tamaiti (child).

6.1 Section One: The conveyance of maternity knowledge through ritual.

To understand why traditional rituals remain crucial to the wellbeing of Māori is to understand what a ritual is and how it functions in Te Ao Māori (the Māori world). A kawa (ritual) is a social behaviour performed for a specific cultural purpose. Symbolic in nature, rituals reinforce beliefs and provide structure and adherence to a set of values. Rituals can convey a cohesiveness and a sense of belonging (Barlow, 1991; Foster, 2002; Marsden, 2003).

Rituals related to maternity care are conducted at preconception when the hine (virgin girl) is being prepared for her first act of copulation or for couples struggling to conceive or for couples wanting a particular gender, and throughout the hapūtanga (pregnancy). Rituals are performed to transmit knowledge to the pēpi in utero and post birth to cleanse the child and mother, whānau members, and the birth location. Rituals dispel the tapu (sacredness) inherited by the mana of regeneration (Barlow, 1991; Beattie, 1990; Best, 1929; Makareti, 1938; Marsden, 1992, 2003). More details are provided on specific childbirth rituals later in this chapter.

Historian, researcher, and writer John White (1887) highlighted the relationship between ritual and myth. He said that pūrākau (mythical stories) and kawa operate together so can only be truly understood when seen as one. Kawa expressed in pūrākau cements a knowledge process or a protection mechanism to retain vital hapū and iwi ethics that assist the wellbeing of that particular collective. Pūrākau act as a repository or a mnemonic expression of important cultural practices (White, 1887). Joseph Campbell (1972) supports this line of thought when he states that ritual (kawa) or cultural practices are enactments of myths. He says, “myths are the mental supports of rites; rites are the physical enactment of myths” (1972, p. 45). Tau (2003) describes Campbell’s ritual discussion as rituals executing the “operational arm of myth” (p. 65).

Mexican Indian writer and healer Patrisia Gonzales (2012) perceives rituals as ceremonies that bring knowledge into action and act as a bridge to ensure ancient knowledge is never forgotten. Ceremonies therefore protect tribal values and practices to ensure their continued existence (Gonzales, 2012). Ceremonies can also be a

protective mechanism that allow a transcendence of linear time and transportation spiritually to the original time that the stories happened. Armstrong (2005) approaches rituals in a pragmatic way when she discusses rituals as multi-dimensional. Armstrong (2005) claims that rituals bring mythology to life by acting out the myth through the ritualistic practice, analysing how it impacts on life, and then gaining new knowledge from this process.

Campbell (1972) asserts that rituals form and inform life; a developing child is raised watching rituals and hearing mythology, so the myths become embossed into the child's understanding of themselves and the world around them. Therefore, ritualistic ceremonies continue to keep the mind harmonised with the body, centering the child within their culture and within the larger extensive system and, therefore, hold particular importance when teaching the young about their social and natural environment. Campbell (1972) describes ritual as giving external form to human life. When babies are born, they are unlike any other species. Campbell states that our central nervous system is not closed like other species', but open to receiving imprinting from within the society we are raised. These etchings are learned during our early years and are transmitted through ritual.

Kawa is a term Marsden (2003) uses to describe ritual and he concurs with Gonzales that kawa protect and reinforce the awareness and importance of tribal history and values. Great importance was given to conducting kawa correctly as failing to do so was viewed as an "ill-omen" concerning the conductor of the ritual and those the ritual was regarding (p. 48). However, as society has evolved, the practice of ritual has changed. Campbell (1972) argues that religion once maintained rituals in every occasion. Although, over time, rituals have become less carried by religion and some societal rituals have remained which highlighted that rituals were not dependent on religion for survival.

Karakia (invocations) are a central component of all Māori rituals, and they provide the oratory to aid the effectiveness of what is being applied, intended or required. However, the loss of kaumātua (Māori elders) who were proficient in te reo Māori (Māori language), and who were confident and competent in providing appropriate kawa and karakia, is one of the key reasons for the decline in kawa practices for Māori (Marsden, 1992, 2003).

Karakia

Karakia are another repository of ancient Māori knowledge that inform and sit alongside ritual practices and, in particular, birthing rituals. Teone Tikao (1990) reiterates that karakia were designed to seek the help of the atua (gods), or a particular atua, to aid good intent or be used to cast mākutū (spell) over a person or thing. Karakia, Tikao explains, were issued to initiate and to dispel tapu (sacredness). As Marsden (1992, 2003) stressed that karakia needed to be recited word perfect in ritual ceremonies to avoid misfortune; the tohunga carried this level of expertise and mana and therefore were given the task of conducting karakia. They were considered tapu and they avoided coming into contact with objects and entities that conflicted their taputanga, such as cooked food. Regarding pregnancy, karakia were recited before conception and throughout the hapūtanga (pregnancy), birth and postnatally.

Ritual often aligned with environmental elements: water, fire and earth. These elements were often used to enhance the potency of the ritual. Fire gave greater power to the ritual; the earth element represented the mana of Papatūānuku (Earth Mother). A small scraping of earth was taken from an existing tūāhu (shrine) to replicate the spiritual value of Papatūānuku (Best, 1975, 2005; Te Rangi Hiroa, 1949). Water was used as a purifier, removing personal pollutants to cleanse the person or people involved with the ritual (Beatties, 2004; Best, 1975, 2005; Te Rangi Hiroa, 1949). Tikao (1990) states that Southern tohuka (tohunga/specialists) had no use for water apart from anointing a person during a ceremony, or if the ceremony took place in a crystal clear puna (pool of water) known to be a wahi tapu (sacred place). Tikao claimed that the sacred fires hold the greatest mana for him. He explained that mana was present at the beginning of the creation of the universe and will be at the end of the world; it is mana that keeps the world moving, turning and evolving. Within the old Māori schools of learning, such as the whare pūrakau (the house of weaponry), whare mairi (the house of general knowledge) and the whare kura (the house of tribal history and whakapapa), were the sacred fires of mana (p. 96). Anthropologist and historian Hirini Mead (2003) stated that karakia for childbirth had a dual intention, as they were dedicated to both mother

and child. Karakia would encourage the mother to have strength post birth to ensure good health and welcome the child into this new world (2003).

Henare Te Maire of Waihao likens the words uttered by tohunga in karakia as ahi tapu (sacred fires) when they spoke to or for the atua (Beattie, 1994). According to Tikao (1990), the tūāhu (altar) was a sanctified space, and situated alongside the tūāhu was the sacred fire embedded in the soil and often covered by a stone to signpost its location (p. 71). The use of special fires within ritual originated from the celestial realm. Best (1982) spoke of fire as a gift to mankind from the sun; fire was frequently personified and named Mahuika (the atua of fire) and shared in Māori mythology as a vital commodity to be admired and feared. Tohunga would call upon an atua and would bring their energy into the fire, giving both the fire and the ritual more potency (Best, 1982; Cowan & Pomare, 1930). Fire was also used to burn something away; in birthing practices, the temporary shelter – the whare kohanga (temporary birthing house) – was sacked to remove the tapu (sacred) of birth and return the area to noa (free from sacredness) (Best, 1975).

The details within a karakia dictated the lineage of the person receiving it. Those of senior whakapapa lines would receive karakia that contained the superior atua (gods), whereas others would be given karakia with the next tier of atua, clearly distinguishing the hierarchical nature of lineage and karakia (Beattie, 1994; Best, 1975; Hakopa, 2011; Pitama, 2011; Smith, 1899). Erena Raukura Gillies of Rapaki (2016) understood that the recital of conception karakia were often performed for high-ranking puhi (virgins) to prepare them for marriage and often took place after their first menstruation. In Māori society, the first-born of the most senior family was known as the ariki (chief of that society). The senior family were able to trace their descent through all the ariki to the founding ancestor of the iwi (tribe) or hapū (subtribe). Māori aristocracy was treated with the utmost respect and rituals such as karakia and waiata acknowledged their status and the importance of procreation (Mahuika, 1992).

The following is an example of a karakia (incantation), *Na te Ao*, written by Matiaha Tiramōrehu of Ngāi Tahu descent. This karakia describes a creation whakapapa with the many dominions of darkness, chasms of space and then light stratum, and couplings of environmental dominions eventuating in the birth of humanity:

Ko te Ao Tūroa – the physical world
 Tāna ko Te Ao Marama – the world of light
 Na Te Kore – came from the void of potential
 Tāna ko Te Kore Whiwhia – the void of which nothing is possessed or obtained
 Tāna ko Te Kore Te Kerekere – the intense night
 Tāna ko Te Kore Te Taumaua – the void without time and space limits
 Tāna ko Te Kore Te Matua – the void without parental origin
 Tāna ko Mākū – Māku the entity representing damp and moisture
 Ka moe ia i a Mahoranuiātea – partnered with Mahoranuiātea (to clear and expand) from which came
 Ko te Raki – Raki the sky father Rakinui then he
 Ka moe ia i a Pokoharunuietepō – partnered with Pokoharunuietepō
 Ko Aoraki me Rakamaomao tana a Tāwhiri a Matea - Aoraki the mountain and Rakamaomao and from this union came Aoraki the maunga and the source of the great winds of Rakamaomao and Tāwhiri a Matea
 Ko Tū te Rakiwhanoa – Tū te Rakiwhanoa is a demi-god who carved the fiords in the far south
 Uira ki Te Mahunui a Maui – Maui's waka Mahunui appeared like lightening signaling Maui's arrival
 Ko Te Ao Tākata – bringing forth the world of humanity

Māori Marsden (2003) describes the evolution of the universe as a progression that was comprised of a succession of realms that were bound and connected through the spirit, and over a vast amount of time the natural world emerged (2003, p. 31). Marsden (2003) terms it a three-world system, starting with Io who formed potential in Te Korekore (the void), which materialised from the spiritual in Te Pō and birthed into the physical world of Te Ao Marama (the world of light) (p. 20). Historian Te Maire Tau (2015) believes Marsden's description of the creation narrative aligns closely with the Ngāi Tahu creation accounts, such as the *Raro Timu Raro Take* creation karakia that Tikao shared with historian Herries Beattie in 1920. This karakia commences in the water, and denotes that all life came from the ocean. Io raised Rakinui (Sky Father) and Papatūānuku (Earth Mother) from the ocean, providing platforms for all other living entities to perch upon and ascend from (Beattie, 1990). *Raro Timu Raro Take* karakia and the translation are located in Chapter Two on p. 35).

Creation karakia inform and reiterate how Māori, specifically Ngāi Tahu, came into existence. The repetition of these creation karakia to prepare the wāhine and tane for conception, the development of the foetus in utero, and the eventual birth that spiritually prepare the child for their role and responsibilities in the world they are being birthed

into. Karakia describe whakapapa to inform, to prepare, to insert, to strengthen and to protect. An example of this, is in the Ngāi Tahu karakia from White's manuscripts (1826) used when there is a birth complication:

Ka tae ki whānautanga tamaiti ma ngā mātua e whakawhānau.
During the woman's labour.
Ka matapouri te wāhine, me tiki ngā tohunga karakia ai – ka whānau te tamaiti.
She struggled through the labour and a tribal specialist was fetched to perform karakia.
Kaore ano kia whānau noa me whakatapu te tamaiti – e kore e tuku te wāhine kia waha kai.
Yet this did not bring forth the child. The mother couldn't birth the child.
Whānau mai tapu tonu ai te tamaiti.
The birth of the child was hindered by an infringement of tapu.

This text above relates to the birth of Tū Āhuriri, which was reported as a difficult and long birth. The larger context of this snippet above is that the tohunga (specialist) was called to recite karakia to hasten the labour. However, at the conclusion of the karakia that recounted the baby's whakapapa nothing happened. It was then suggested that the tohunga try another whakapapa, as the child was not responding to the whakapapa of Tumaro. Upon the recital of another whakapapa, belonging to Te Aohikuraki, the child came forth. This story highlights the strength of karakia to aid labour and the importance for the karakia whakapapa to be correct.

White included Wohler's writings in his book, *Ancient History of the Māori* (1887). The following Ngāi Tahu karakia were recited at the birth of a pēpi. The repetitive use of the word "uha" (femininity) references the cervix, birth canal or vagina as the pēpi transcends completely out of their mother's body. The term "Ka pō te uha" (the femininity is darkened) is used, which suggests that post birth the cervix begins to close, and the birth canal becomes dark. It seems that this karakia is addressing the pēpi, calling the pēpi into being, into the realm of Te Ao Marama (the world of light) (Morgan, 2020; White, 1887).

Mohura, mowairaka
Ka pō te uha, te uha
Me paka ki whea
Te piro, te uha
Te rae, te uha
Te uru, te uha
Te tukemata, te uha,
Te ihu, te uha
Te konohi, te uha
Te taringa, te uha
Te waha, te uha
Te kaki, te uha
Te keke, te uha
Te u, te uha
Te poho, te uha
Te kaokao, te uha
Te tuara, te uha
Te pito, te uha
Te hope, te uha
Te papa, te uha
Te kumu, te uha
Te tinana, te uha
Te io, te uha
Te pona, te uha
Te waewae, te uha
Mohura, mowairaka
Ka pō te uha
(White, 1887)

Karakia in traditional birthing practices conveyed knowledge and significant historical events, and gave direction to the mother, whānau and pēpi. Mexican Indian people also used prayers and blessings during labour. Both the mother and/or father would conduct prayers to evoke spiritual protectors, which would alleviate the mother's uncertainty and worries around birth (Poma, 1987). Maria de la Cruz is an Indigenous midwife and she reiterates that praying helps women get through the pain and exhaustion during labour. De la Cruz describes this more visibly when she says the "womb is a site of ceremony" and praying is a ritual that pays homage to this ceremony and guides women through labour and birth (Gonzales, 2012, p.63).

Tūā

Tikao (1990) used the term “tūā” (naming ritual) instead of “pure” (cleansing purification to remove the sacredness), yet the terms appear to have the same intent. He said that the tohuka (specialist) would take the child to a heat source, such as a sacred fire at the base of a tūāhu (altar), and then to water (wai tapu). He would dip a tree branch into the water and sprinkle the water over the child and sometimes the child was given a name at this point. At the completion of the tūā ritual, the child was deemed free from tapu (Beattie, 1990, p. 74; Marsden, 2003). An account given in the Chatham Islands refers to a process similar to a tūā process but not named; this involved a Morirori tohunga dipping the kawakawa branch into the water and waving it over the wāhine hapū to protect the unborn child from any evil spirits (Beattie, 1994; Mead, 2003).

John White’s collection at the Alexander Turnbull library features a manuscript under the inauspicious title of ‘Miscellaneous’ that was originally in a package labeled ‘Nothing notable’, intended for Elsdon Best (MS 1187-201). This manuscript contains writings from Reverend Creed and Reverend Wohler from their experiences of Māori life in the South Island and, in particular, around the Otago and Murihiku area in the mid 1840s. Tahu Potiki (2019) sent me these pieces of text and karakia from White’s collection.

Hei te makeretanga o te pito (8 or 10 days) he karakia tapu rawa, nui rawa. Ka pikau te tamaiti ki te wai, ka haere hoki te hakui, karakia ai, titiro ai ki nga tohu mate o te tamaiti. He tūā te karakia. Karia nga puna. Ko Punatamatane, Ko Punatamawāhine.

An attempt at the translation is as follows:

At the falling away of the child’s pito (umbilical stump) which took place around 8-10 days – a very sacred incantation would be performed over the child. The child would be carried in their baby backpack to the water, the mother would go also, and incantations would take place. The child would be observed carefully to ensure the child’s wellbeing was upmost. It was a tūā ceremony that took place that is a specific cleansing karakia post birth and performed at a designated water site. It would be a specific water hole for a female baby or a male baby (Morgan, 2020).

Tohi

In contrast to the pure ritual is the tohi ceremony. This tohi ritual was the sacramental process that placed a person under tapu and provided them with mana (King, 1992, p. 124). Although the author of *Māori Women*, Berys Heuer (1972), mentions in her writings other names associated with the birthing purification rituals, such as iri, iriiri or whakairi, the intent appeared similar to all the purification ceremonies, and that was to encourage the young child to grow up healthy and to align their strengths to a practical skill. Beattie's informants in her book, *Traditional Lifeways of the Southern Māori*, state that the term iriiri is the name given post-Christianity and refers to the baptism babies received. The Southern term for the cleansing ceremonial is the tohi – this is the older and preferred Ngāi Tahu term for this ceremony (1994).

Tikao (1990) describes the tohi process as something similar to a baptism; a name is bestowed upon the newborn, and the karakia (incantation) used during a tohi ceremony authorised the mana within a child, as mentioned by Marsden (2003), and protected the child's life. Tikao associated the tohi ritual mostly with children born from chiefly lines (Beattie, 1990, p. 97, 1994).

Keane (2011) says that the tohi ceremony would follow the tūā ritual again near water. Beattie (1994) states that his Southern informants told him the tohi ceremony involved the tohunga taking the baby to the waitapu (sacred waters) to conduct the tohi ceremony in those waters; the hapū often saw the chosen water as a sacred place. The karakia during this ceremony directed the child to remain forever strong in their spirituality to fervently protect their mana for eternity. This ceremony also served as a whakanoa (cleansing process) for the pakeke (adults) who had taken part in all the other birthing ceremonies. This celebration or ceremony metaphorically shifted people from the sacred arena through karakia (invocations) and the removal of tapu, and into a noa or common space.

Below is an example of what appears to be an incomplete karakia used within a tohi ceremony with some descriptive notes taken from White's anthology of writings (1887), with collected works from others, such as Reverend Creed and Wohler in the

1840s. I have not translated this karakia but can propose the overall intent. The karakia below appears to dedicate the pēpi to the realm of Tūmatauenga and is likely to have been used in the devotion of a male child. Tohi were used to endow the child with skills, attributes and virtues of the chosen god.

Rau i toa
Rau i tokotoko
Tama ki te wai
Tama whakateki
Rau i mapere
Rau i huata
Rau i whaketeki
E riri ai
E kuha ai
E toa ai
Ki te wai o Tutawake
Tohi mai ra
Tohi mai ra
Tohi mauri ora

The sentences below were located with the karakia and appear to be instructional. A suggested translation follows this text.

Ka karangatia te ingoa e te tupuna tonu, e te tāngata tonu
Me he wāhine te tamaiti me homai he muka ki te ringa o te tamaiti mau ai, ka karakia ko aua kupu ano.
Ka tapuke te pito ki te wahi tapu. Ka hoki mai ki te kainga tau umu tapu ai. He umu ke mō te Tauranga, ma ngā poua tapu e kai. He umu kē mō te tukuwewe mō ngā matua o te tamaiti e kai. He tapu hoki (White, 1887).

The name of the child is called out by the grandparent or related elder.
If the child is female, a prepared flax fibre is placed in the child's hand to hold and the incantation is repeated.
The placenta is buried at a sacred site. Those involved in the process then return home and partake in the sacred meal. There is an oven reserved for the tohunga, and the sacred elders to eat from. There is another oven for the close relatives and the parents of the child to eat from. This is also sacred (Morgan, 2020).

There is discrepancy over the words “Tauranga” and “tukuwewe”, as it could be suggested that Tauranga was a mistake made in dictation and perhaps was meant to read tohunga. No reference could be found for tukuwewe, but it is thought that it could be similar to “eweewe” which is “close relatives” (Morgan, 2020).

Ritualistic practices hold old knowledge that impart cultural values and provide guidance to the hapū, whānau and the mother with child. These maternity practices prepare the whānau and the labouring mother pre- and post-birth with cleansing rituals that ensure the process has been spiritually and physically completed. In the case of the Mexican Indian peoples, they have similar cleansing rituals, such as the closing of the womb ceremony which they consider the final stage of pregnancy. It is a thanking ceremony that acknowledges the mother's body for the energy and effort it has undergone to hold, sustain and nurture the baby to fruition. The mother will undertake this ceremony approximately two weeks post birth by sitting in a warm bath. This is followed by her body being massaged and wrapped tightly in a binding body cloth locking the heat into the body. This deep form of relaxation is in honour of the mother and is a symbolic gesture referring to the closing of the womb.

Whe (sound)

Although, no written material spoke about the use of taonga pūoro in the Southern births, an account was passed on by Tuhoe elders to Hirini Melbourne and Richard Nunns regarding a particular breathy flute, called a pūmotomoto. The pūmotomoto was specifically played to relay messages to the developing foetus in utero and played either directly to the where tāngata (uterus) or, post birth, towards the child's fontanelle (Nunns, 2011). Nunn's (2011) asserted that while the hearing of a fetus is developing in utero is an optimum time to be playing traditional Māori instruments, such as the kōauau (flute) or the pūmotomoto (a variation of a flute), directly to the maturing foetus.

Taonga pūoro (traditional Māori musician) artist Richard Nunns (2011) supports this creation concept, particularly the role of whe. He says that while the hearing of a fetus is developing in utero, it is an optimal time to be playing traditional Māori instruments, such as the kōauau (flute) or the pūmotomoto (a variation of a flute), directly to the maturing fetus. Taonga pūoro is another way Māori transferred knowledge. Nunns emphasised that it was not only the sound these ancient instruments made but also the vibrations they created through the membranes to the developing fetus. Upon hearing the husky, breathy voice of the pūmotomoto, it is easy to sense the vibrations. Raina Sciascia of Ngāi Tahu teaches oriori to wāhine in her mana karanga wānanga, and she

agrees with Nunns and Marsden that vibrations are another knowledge transferal medium. She says the *ihirangaranga* (vibrations or sound waves) access old files encoded within the child's mind. Sciascia said the sound of the *oriori* resonates within the child through the words and vibrations (2017).

Marsden associates *whe* (sound) with *wānanga*, he claims that *wānanga* means to discuss, workshop and debate, yet, when combined with *whe*, Marsden explains it means wisdom. *Whe* represents the embryo or the seed of a word that is then later clothed with the *kahu* (dress) and evolves into a concept that is birthed into a word. Marsden argues that *wānanga* and *whe* cannot exist without the other as they assist the existence of each other (Marsden, 1992, p. 6).

Flintoff made a replica from the description given by the *kaumātua*, and *taonga pūoro* player Richard Nunns experimented with the function of the *pūmotomoto* with *hapū wāhine* with positive results. *Hapū wāhine* took part in a *wānanga hapūtanga* I organised in 2010 and experienced the playing of the *pūmotomoto* to their *pēpi* in utero by Richard Nunns. They expressed in reflection that they could feel the vibrations of the *pūmotomoto* going through them and they felt their *pēpi* move gently to the sound. They said it was both relaxing and intriguing. Nunns spoke into the instrument, as the *Tuhoe* elders had said was done, often referencing significant events and aspirations for the child (Tikao, 2013).

The human voice was another musical instrument used throughout the birthing process. *Waiata* (song) performed by the labouring *wāhine* or those attending to her provided relief, distraction and another opportunity to share stories with the developing *pēpi* (A. Clarke, Ngāi Tahu, Māori midwife; M. Crofts, Ngāi Tahu, *kaumātua*). The role of *waiata* and *oriori* is discussed in the next section.

6.2 Section Two: Waiata and Oriori

Waiata sung to pēpi in utero, during, and after birth were known as oriori (lullaby). These were performed by the labouring wāhine or those attending to her. The oriori and other forms of waiata provided a form of pain relief by offering a rhythmic chant to move to, or breathe the pain through, whilst listening or singing. Clarke (Ngāi Tahu, Māori midwife) used waiata in her midwifery practice to relax the breathing and the muscles around the perineum of labouring mothers. Waiata can be used to connect the mother to her taha Māori (Māori being) by listening to the words of a sung whakapapa, sung karakia or well-known iwi tunes that promote a sense of pride and strength (Clarke, Ngāi Tahu, Māori midwife). Waiata carried profound tribal knowledge about whakapapa, tribal warfare, significant people, marriages, connections between iwi and hapū, and the natural and the spiritual world. Waiata were also used to entertain, to make light of situations, to show gratitude and as a gift (Ka'ai-Mahuta, 2010; Mead, 1969).

The use of ancient waiata and the composition of new waiata have continued the tradition of incorporating current issues affecting te iwi Māori or a notable Māori figure in the composition of the waiata (Ka'ai-Mahuta, 2010; Mead, 1969). We hear some of the older styles of waiata less frequently; however, the overall function of many waiata has survived. The current revival of te reo Māori (the Māori language) in Aotearoa brings promise for the return of some of the older styles of waiata that carried a history of yesteryear and now are forgotten tribal knowledge (Hill, 2018; Ka'ai-Mahuta, 2010; May & Hill, 2018; Mead, 1969).

Anthropologist and historian Hirini Mead (1969) says that, despite all the exposure to many other cultures from Europe and America, waiata Māori have remained intact. He alleges that the waiata repertoire has reduced as the expression of certain tikanga has diminished. However, overall waiata Māori have retained the same characteristic expression as recorded by earlier historians and settlers (Colenso, 1880; Grey, 1953; Mead, 1969).

Mead (1969) describes a difference in composition of waiata between females and males. He says that females express their emotions about specific events, whereas males

would include mythology and use more exaggerated language in their compositions. Mead (1969) also notes that both sexes emphasise particular cultural symbols that lie beneath a cultural value. So, the use of mountains, rivers and well-known ancestors, for example, are common in waiata composition. The use of tūpuna names provide enough identification of which iwi the waiata belongs to without naming the iwi (tribe) or hapū (sub-tribe).

In 1849, Matiaha Tiramorehu of Moeraki relayed a creation kōrero (story) that spoke of the gods singing the world into existence:

Kei a te Pō te tīmatanga o te waiatatanga mai a te Atua. Na Te Pō, Ko te Ao, Na
te Ao, ko te Ao Marama,
Ko te Ao Marama, ko te Ao Tūroa.
It was in the night, that the Gods sang the world into existence.
From the world of light, into the long-standing day.
(Flintoff, 2004, p. 12; Melbourne, Nunns & Yates-Smith, 2003; Tiramorehu, 1987).

This excited those in later generations who are revitalising the taonga pūoro Māori (ancient Māori musical instruments), such as master carver and taonga pūoro artist Brian Flintoff, the late Hirini Melbourne, and Richard Nunns. Flintoff wrote that all the varying types of waiata Māori originate from the intensity of emotions imparted by the stories of creation waiata of: lament, anger, loss, despair, peace, happiness and love. The taonga pūoro, he argues, are the voices that embellish the poems within the waiata (Flintoff, 2004, p. 12).

Specific waiata, such as oriori, were sung throughout gestation. Oriori are often translated as children's lullabies or sung karakia (invocations) and, although sung to all pēpi, the ones most noted are those sung at the births of high-ranking children. Primarily, oriori were dedicated to the pēpi, yet they also imparted messages to parents to set them to the task of raising the child well to best meet the desires and goals set forth in the oriori. Mead (1969) states that he found that oriori composed by female relatives were predominantly for female children and males composed the majority of oriori for male children of high rank. Again, important ancestors, places and treasured objects are written into oriori and Mead argues that there were two approaches to oriori. The first being that the oriori takes the child on a genealogical and geographical journey, which allows more historical detail, such as battle sites and landmarks, to be

incorporated into the oriori. The second approach to oriori composition is when the theme becomes integral to the waiata (1969, p. 384).

Amster Reedy (2008) completed his doctorate on oriori and reported that oriori can be used to prepare wāhine for conception and throughout their pregnancy, but he reiterated the optimum time to perform oriori is at the point of birth. It is at this time that the child has completed their spiritual journey and is about to enter the physical realm. This is the phase of knowledge transmission between the celestial and terrestrial realms. Māori Marsden (2003) described this point of knowledge transfer as an acquisition between the kauae runga and kauae raro. Kauae runga is the term for the upper jaw of a person but it is also known as the upper level of learning or higher learning achieved through the whare wānanga of the ancient Māori. Kauae raro is the lower jaw, and this pertains to knowledge of occult lore and varying karakia taught within the whare maire. Reedy said oriori are an illustration of how intimate Māori tupuna were with the environment they lived in. The many stanzas within oriori contain intricate detail that unfolds the world that lays in wait for the child (2008).

It was noted in McClean and Orbell's (2004) book on traditional Māori waiata that, similar to other Māori concepts, waiata text and hearing it be sung cannot be regarded in isolation from each other. Difficulties in the text can be resolved after connecting the sound, if possible, to it and seeing why and how the text was phrased as such. A degree of understanding about the historical context of when they were written and by whom contributes towards the translation of waiata. Significant tribal history, inclusive of people, events and places, were composed in waiata. This made the older waiata difficult to translate accurately unless the translator had prior knowledge of the tribal history, geography and the event the waiata may have been depicting. Regardless, these waiata still encapsulated knowledge that may have been lost otherwise and preserving what we have left is a tribal challenge.

Many Kāi Tahu elders remembered the kōrero from their grandparents and some remembered hearing the waiata being sung for wāhine hapū (pregnant women) during labour and birth when they were little. They described it as a collective of taua or ruahine (grandmothers) gathered in the whare surrounding the wāhine hapū and singing. Rik Pitama (2016) remembers his mother, Malta Tikao, speaking of her

whanaunga Amiria Puhirere at Ōnuku birthing babies in the area and putting a tono (request) out to the taua (grandmothers) to come and do waiata for wāhine in labour.

I remember a reference to a water birth below a waterfall, I think on the road down to Ōnawe from Hilltop Tavern. The *taua* of our great grandparents time would gather around their irāmutu (nieces and nephews) about to give birth, waiata mai ngā waiata (singing songs) and often a tohunga (tribal specialist) would recite whakapapa (family lineage) to offer an appropriate ingoa-tupuna (ancestral name) (R.Pitama, Ngāi Tahu, kaumātua).

Meri Crofts (2018) was raised by her taua, Meri Matehaere Ruru of Puari (Port Levy), and poua, Poihipi Te Hua of Tūāhiwi, and she remembers her taua Meri speaking about her own births. Taua Meri recalled how the taua from Tūāhiwi would come into the tent where she was living with kai and they would sing waiata and do karakia over her when she was hapū (pregnant). Meri told her mokopuna (grandchild) she felt very loved by all the taua and received a lot of support (R. Pitama and W. Tikao, Ngāi Tahu, kaumātua).

The following examples of waiata serve to highlight the use of waiata as a ritual to provide support, guidance, and transference of knowledge to both the mother and her child in utero when sung during pregnancy, labour and post birth to the child.

The following waiata was dictated by Teone Tikao to Herries Beattie at Rapaki on November 17th, 1920 and was found in the Beattie manuscripts.

Ka noho a Tane, ka noho a Hinetītama, ka timātia te pō, ko titamātia te ao.
Tane was married to Hinetītama, at the beginning of darkness, the beginning of light

Ka uia e reira, “ko wai te matua nana nei au?”
Hinetītama asked, who are my parents? (Tane had always avoided her question)
both day and night had no answer to her query.

E ui rā ki te poupou o te whare – kaore te ki mai kei waha
She asked the posts of the house – they did not answer

E ui rā ki te pakitara o te whare – kaore te ki mai te waha
She asked the walls of the house – they did not answer

E ui rā ki te tahu o te whare – kaore te ki mai te waha
She asked the roof of the house – it did not answer

E ui rā ki te maihi o te whare – kaore te ki mai te waha
She asked the apex of the verandah – it did not answer

E mate rā e te whakamā ki nunumi ka tawhe ki te rara o Pou-tū-te-Rangi nei.
Suffering there from bashfulness and shamed face she grabbed her daughters and
fled past Pou-tū-te-Rangi to Te Reika (the underworld)

“E haere ana koe e Tane ki whea?”

“E whai atu ana au nei i a taua hui nei”

When Tane returned he was told that his wife had fled, and he sniffed the wind
and knew which direction she had headed.

E hoki e Tane ki te ao he whakatipu mai i a taua hua nei. Tukua ake au ki te pō
hei kukume atu ia ō Tane.

Hinetītama told Tane to return to the world of the living to raise the people and
she will proceed to drag them towards her (towards death).

Taua hua nei. Tangohia mai nei e koe ko ngā Tupuni a Wehi-nui-a Maomao; ko
Hirauta, ko Hiratai, ko Te Parinuku, ko Te Parirangi. Tangohia mai nei e koe ko
Te Kahui-whetu, Puanga nei Takurua nei, e Meremere nei e Aotahi-ma-Rehua
nei he Ariki koe no te tau

Take with you the coverings of the god Wehi nui a Maomao, the stars, Hirauta,
Hiratai, Parinuku, Te Parirangi. Take the collection of stars named Puanga,
Takurua, Meremere, Aotahi ma Rehua that is the head chief for the year.

E whakaneke Pungarehu nei e, ko Uaki motumotu nei e, ko Werote ninihi nei e,
Ko Wero-te-kokota nei e, Ko Wero te Aumaria nei e Te Ahuru nei e, Te Wewera
nei e, Te Manakotea nei, ko Whiti kau peka, Ko Te Ika o te Rangi, ko Te Kore.
Move these stars: Pungarehu, Uaki motumotu, Wero te ninihi, Wero te kokota,
Wero te Aumaria, Te Ahuru, Te Wewera, Te Mahana in the proximity to the sky
to decorate him also Manakotea, Whitikaupeka, Te Ika o te Rangi and Te Kore.

This oriori was a lament from Hinetītama for the life she was forced to leave in its
physical state through no actions of her own but that of Tane. The level of her shame
intensified through the awareness that Tane was both her husband and her father and
that other factions knew this before her. Conflicted with emotion and vulnerability to
the truth, Hinetītama fled. She formulated her plan and when Tane learned of her
departure he followed her. Hinetītama was adamant she would not return with Tane and
she gathered her strength in her final delivery when she retorted to his plea for her
return. She told him to return to the Ao Tūroa (physical world) and proceed to procreate
and that she would drag them to the underworld to be with her. She then told him to
take a collection of specific stars and adorn Rakinui (the Sky Father), which could be

interpreted as a forever remembrance of Tane's mistake and a perhaps a symbol of his lost love.

Teone Tikao dictated this oriori to Herries Beattie on the 18th of November 1920. This old waiata was sung to settle a crying pēpi whilst being nursed. Nestled among the soothing lyrics are stories of the ancient past.

E tama, hoki koe nahaku e whakaputa nei koi i tērā o te waru
Oh son, return thou to me bringing forth this vitality in the sun for eight months

Kai te putanga i tua, kai te putanga i whea, kai te Huareare i puta mai ra koe, e tama.

Appearing on this side, appearing where it is Te Huareare (the name of the Moon's mother) brought forth by you, oh son, brought forth in the time

Ia Te Moretu, Ia Te Moremau, Ia Te Moretaketake
of Te Moretu (tree planting), of Te Moremau (to ensure the roots are embedded in the earth) and Te Moretaketake (the tree is firmly planted).

Kihai i ea i a Te Mākū ngā pou a Tāwhiti, nga pou a to tipuna ahua torikiriki.
Not emerging in the time of Te Mākū (wet season), the posts of Tāwhiti (child of Ranginui and meaning in the distance), the posts of thy ancestors appearing small (Torikiriki is another child of Ranginui and can refer to being in the distant and faint)

I whakarerea anō ki te Pō Rangahau, a ki te Poutū mai o waho, a ki te Poutū mai
And made to fly to Pō Rangahau to Poutū outside to Poutū

o roto, a ki te Pou hereti, a ki te Pou herata, ki hereti Pou hakohako.
and inside to Pou hereti, to Pouhata, to Pou hakohako

Ko te Ao tūroa, ko te Ao Marama, ko whatiwhati pea, e Tama, te tai nui e ka
Names of god-like beings, being broken off perhaps, oh son, the great tide
whakakana nga kanohi o te rangi e tu nei to Te Pou herata (another term for
causing to shine the eyes of the sky fixed up there
fasten tight), to Pou hakohako (to dig in)
The gods Ao-turoa (natural world) and Ao-mārama (physical world) have
perhaps been severed, oh son.

The waiata acknowledges the gestation period and growth of the pēpi over the nine months whilst in utero, moving into place to be born as the moon's pull encourages him to come forth, but not before he is fully developed. There is a warning or guidance in this oriori to ensure the child is fully prepared into his/her form, is robust and sturdy, has taken the time to ensure these vital core elements to his/her form, mind and journey

ahead are in place. It captures the excitement in anticipation of the arrival of this pēpi. The oriori uses the metaphor of a tree, which is often a reference for life and growth (Beattie, 1920; Best, 1942; Riley, 1994). It refers also to Tane Mahuta's feat of raising his father, Rakinui, away from his mother, Papatūānuku, in order to create light for their children. The caution comes when the oriori tells the child to avoid the winter months or long periods of rain, as this makes it difficult for people to come and assist or be present at the birth and to support the whānau. The final part of the oriori could be interpreted as the final guidance or tautoko (support) being imparted to the unborn child to come forth into the physical world full of light; the stars are shining and the Atua have blessed your journey (Beattie, 1920).

Apirana Ngata's *Ngā Moteatea* series (Volume One) in the Journal of the Polynesian Society (1928) featured the oriori below for Hinekitāwhiti of Ngāti Porou. This is significant for Ngāi Tahu because of the relationship between Tahu Potiki, a descendant from Paikea, and his younger brother, Porourangi, from which the tribe Ngāti Porou were named. It is believed that many waiata that originated from a particular tribal area have traveled with the iwi. As they migrated to other places these waiata have been adapted to accommodate a new need, person, or place (Mead, 1969).

Hinekitāwhiti composed the original version of the waiata below, titled *Kia Tapu hoki Koe*, for her grandson, Ahuahukiterangi. Hinekitāwhiti's daughter-in-law, Hinetuahoanga, was the daughter of Te Auiti, the son of Makahuri who descends from one of the noble Ngāti Porou whānau. They all lived at Te Ariuru, situated at the northern end of Tokomaru Bay on the East Coast of the North Island (Ngata, 1944). This is the original version of this oriori:

Kia tapu hoki koe na Tuariki e!
Be thou apart, offspring of Tuariki

Kia tapu hoki koe na Porouhorea!
Be thou apart, offspring of Porouhea

Kāti nei e noa ko tō taina e!
Let thy younger brother be,

Whakānga i runga ra he kauwhau ariki e
But move thou in exclusive circle, thou of lordly line

Koi tata iho koe ki ngā wahi noa

Ne'er alright on common ground

Whakaturia to tira hei Ngapunarua
Let Ngapunarua be thy starting point

Tahuri o mata ngā kohu tapui,
Turn thine eyes to gathering clouds

Kei runga o te Kautuku, e rapa ana hine
O'er Kautuku Hill; for my lady is seeking

I te kauwhau mua i a Hinemakaho
An exalted line from Hinemakaho

Hai a Hinerautu hai a Tikitikiorangi hai
From Hinerautu and Tikitiki-o-rangi

Hai kona ra korua e!
Greeting to you both

Ana, e koro! Auaka e whangaia ki te umu nui,
Her receive, Sire, of the common umu

Whangaia iho ra ki te umu ki tahaki,
She may not taste

Hai te pongi matapo hai katamu mahana,
Let her eat only the choicest taro

Kia ora ai hine, takawhaki atu ana
Refreshed, let my lady pursue her course

Ngā moka one ra i roto o Punaruku,
Until at Punaruku beach she arrives

Tena Te Rangitumoana mana e whakapeka,
Her Te Rangitumoana would welcome

Moe rawa ki kona, e!
And sleep and rest give her

Mau e ki atu, Arahina ake au,
Thou, may'st ask for a guide on the way

Ki runga o te Huia ki a Ngarangi-kamaea,
To Huia, to Ngarangikamaea

Kia marama au ki roto Tawhitinui
Then thou will clearly see Tawhitinui

Tena ra kakahu mana e ui mai,
Where Kakahu will ask

“Na wai ra tēnei tamaiti e?”
Whose child is this?

Mau e ki atu, “Na te Au a Mawake”
Thou wilt then reply, “From Au a Mawake”

Kia tangi mai ai ō tuakana koka
Thine aunts and cousins will greet thee

I haramai ra koe ngā kauanga i kaituri, na!
And say, thou hast come from Kai turi crossing

I haramai ra koe ngā uru karaka i te Ariuru
Thou hast come past karaka groves at Ariuru

Nahau te mau mai i ngā taonga o Wharawhara
In thine hands, carry the treasures of Wharawhara

Hai tohu rā mohou, kai haengia koe
By these thou wilt recognise be:

Ko te Paekuru ki to taringa, Ko Waikanae ki to ringa
Paekuru in thine ear, Waikanae in thine hand

Hai taputapu mōhou, e hine e!
Precious ornaments for thee, my lady.

This version and translation were taken from Te Ao Hou No. 7 (Summer 1954), and as Hinekitawhiti sung to her mokopuna cradled in her arms she mentioned all the mokopuna’s relatives and significant landmarks and places around Tokomaru and Raukokore (Bay of Plenty). Apirana Ngata classified this particular type of oriori as a genealogical-geographical lullaby for the reasons mentioned above. The intent of the oriori is to locate the child within their whakapapa and whenua.

Tuta Nihoniho penned a version of this oriori more familiar in Te Waipounamu. Nihoniho married into Ngāi Tahu during the 1890s. He titled his version of the same waiata *E tapu rā ko* and dedicated this version to his daughter, Hariata Nihoniho; it is as follows:

E tapu rā koe e Hari na Porourangi ē, e
You are sacred Hariata of Porourangi

Tapu rā koe na Tahu Potiki ē, Whangāngi i runga
You are from the sacred Tahu Potiki ancestry, the line beyond Wellington

Ra he kauhou ariki ē, koi tata noa ki
You are of chiefly heritage, lest you not wonder

Ngā wāhi noa, kāti nei i noa ko Taina a,
To ordinary/common places, do not, these are for those lines below you

Whakaturia to tira hai ngā punarua Tahuri
Establish these guidelines/rules, accept the way it is between tapu and noa

Tō mata ngā kohu tapu, kei runga o Hikurangi
Your face is in a veil of sacred mist (you are shrouded in tapu) from the top of Hikurangi

E rapa ana Hīneite Karehou mua ia Hinemakāho
Embraced by Hine i te Karehou in front of Hinemakāho

Hei ia Te Wioterangi ko wharetuatua kei kona rā
Koutou eī

Te Wioterangi is the main ridge over there
You all.

Ana e hika ma aua koe whangaia ki te
For heaven's sake. You must never eat

Umu nunui whangaia iho rā ki te umu i
From the oven that everyone eats from

Tahaaki hei Te Pongi matapō hei katamu māna
Lest you are to become blinded and eaten with relish by Te Pongi

Kī a ora ai hine taka whakī atu ana kī nga
To live long, daughter, heed to this advice

Moka one i roto Wharepongia tēnā rā to irāmutu
Your nephew, Materoa, is located at the end of the beach inside Wharepongia

Materoa mana e whakapēka mōi kawa ki kona rāi
He refused to believe in these customs of taputanga

Mau e kiate arahina ake āu ki ngā o Hikurangi
You can only go around places/pathways of Hikurangi

Kia kahukura pōri kī a marama ai Te Tiro ki

The rainbow tribe know where this place is called Te Tiro ki

Pautūru kai kona ra To Tupuna a Ruawāhine
Pautūru over there is your ancestor Ruawāhine (taua who can lift tapu)

Mana e ui māi nā wai ra Teenei Tamaiti ē
She will ask whether you are from Teeni Tamati

Mau e kaitu na Raro a Tawāke kī a Tangi
You will respond that you are from Raro a Tawāke

Mai ai o Tipuna i te po ī haeremai ra koe ngā
Your ancestor will then know you have come at night

Kauanga i kai hīakū, haramai ra koe ngā
Crossing over, you come

Kauanga i whirikōka noa atu hau te mau mai i ngā
Through the strong winds to obtain

Taonga o te Atua heī tohu rā mōhou koi hekeia
The treasures of our gods as symbols for you to depart with

Koa ko Te Paipera ia tō runga, ko te karaipi
Joyous is he who wrote the bible

Turu tōna heī ara mōhou e Hine ē
He lived for a short time however, this is a good pathway for you, my daughter.
(Tau, 2017)

Tuta addressed his daughter, Hariata Nihoniho, in this composition and conveyed that she is of a superior ancestral line due to her senior Porourangi and Tahu Potiki heritage. This lineage makes her tapu and he warned Hariata to stay clear of things or places that may disrupt or belittle her hierarchy or tapu, such as food from a common earth oven, certain places she may or may not frequent and activities that are reserved for people of her ranking and other activities that are not. In summary, Tuta's variation on this oriori provided etiquette guidance for Hariata but also the importance of not infringing upon her mana and those she represents (Tau, 2003). Historian Te Maire Tau (2015) says there is another version of this oriori at Tūāhiwi Marae but the kupu for Atua are replaced with the Christian God, and the child is now protected under the paipera tapu (sacred bible).

Another oriori provided a bridge between Te Ika a Maui hapū (subtribes of the North

Island) and Te Waipounamu hapū (South Island hapū), and illustrates that knowledge migrates with Māori and is adapted to accommodate the people and the place. *He oriori mō Tuteremoana* was written by Tūhotoariki, a rangatira and tohunga of Ngāi Tara, and was composed for his great grandnephew, Tuteremoana, who descended from Tara of Ngāi Tara. The messages within this oriori are designed to encourage the child to be the best he can be in combat, harvesting kai (food) and to pursue the mātauranga of Io-matua (knowledge of Supreme being) and within this realm of sacred learning to remember to be honourable. This oriori has a strong connection to Tū Āhuriri through his father, who was Tumaro from Ngāi Tara. The strong correlations between Ngāi Tara whakapapa and Ngāti Ira, and the fact that these two iwi lived at around the same time at the same Pā in Whanganui a Tara before venturing across to Te Waipounamu, led historian Te Maire Tau to surmise that oriori were shared. He argues that the Tuteremoana was also sung over the birth of Tū Āhuriri. The nine verses to this oriori are immense; an example of the first verse follows:

Nau mai e tama, ki a mihi atu au
Welcome, oh son, let me address you

I hara mai rā koe i te kunenga mai o te tāngata
You have indeed come from the origin of mankind

I roto i te āhuru mōwai
From the cosy haven emerged

Ka taka te wai o Huaki-pōuri (Huaki-rangi);
The barrier-of-Darkness-ajar;

Ko te whare hangahanga tēna a
The abode of the renowned

Tāne-nui-a-rangi
Tane of the heavens

I te one i Kura-waka
On the sands of Kura Waka

I tātaia ai te Puhi-raki
Where the exalted was once adorned,

Te hiringa matua, te hiringa tipua
In the implanting of parenthood, sacred implanting

Te hiringa tawhitorangi, e;
Heavenly implanting in times of remote;

Ka karapinepine te pūtoto
Twas then the blood welled forth floodlike

Ki roto te whare wahiawa;
To the house exit:

Ka whakawhetū tama i a ia,
Thus, the son changed into a star,

Ka riro mai a Rua-i-te-pūkenga,
Acquired the recess-of-the-mind,

A Rua-i-te-horahora;
Recess of the spirit;

Ka hōkai tama i a ia, koia hōkai Rauru-nui
Then strove for Rauru-of-renown

Hōkai Rauru-whiwhia,
For a self-possessed Rauru,

Hōkai Rauru-maru-aitu,
And strove against the fate of a stillborn Rauru

Ka mārō tama i te ara namunamu
Son, you remained steadfast on the narrow

Ki te taiao
Pathway to the wide world

Ka kōkiri tama i a ia
Then, o son, you leaped forth

Ki te autūroa, e tama!
Into the enduring world, oh son, ah me!
(Raerino, 1998)

He oriori mō Tūteremoana describes poetically the journey of the pēpi through the mother's labour, which is likened to the birth of the primal offspring of Papatūānuku (Earth Mother) and Ranginui (Sky Father). We follow the birth journey through the verses of the oriori. The beginning welcomes the child and acknowledges that the child is from humankind as it descends from its spiritual realm to the physical world. Gratitude is granted to the whare tāngata (the woman's womb) that nurtured the pēpi through gestation. As the labour progresses and the energy and emotion rise, the bodies

of the woman and child prepare themselves for the final descent. The umbilical cord can be described as a pito, iho or rauru. The rauru is the part of the umbilical cord between the pito and the iho. When assessing the umbilical cord post birth, the state of the rauru can show how the labour may have transpired. A normal birth is described as rauru nui, a healthy or normal-looking umbilical cord. The rauru whiwhia describes a prolonged and difficult labour; the cause of which could be an entangled cord, a breech birth with a limb presenting first. A rauru motu describes a severed umbilical cord resulting in a disabled child and an ill mother. A rauru maru-aitu depicts an extended labour that led to the death of the child (Best, 1929). Therefore, in the waiata oriori above, the unborn child is given all the encouragement to be strong and steadfast during their birth and to succeed the hurdles of labour to reach the world of light; the physical world (Best, 1929; Tiramorehu, 1987). Singing oriori often brings whānau and hapū closer, highlights the communal aspect of Māori birth as opposed to a solitary event, and honours the primal creation narrative as a tribute to the survival of whakapapa.

Ka'ai-Mahuta (2010) credits waiata for preserving tribal history, politics, landmarks and whakapapa, as well as providing a platform to express emotions such as love, hate, sadness and joy. They link people to places and to each other and, according to Ka'ai-Mahuta (2010) and McRae (2004), waiata connect Māori to their identity and to their whānau, hapū and iwi. Other artforms that embed iwi archival knowledge are: mahi whakairo (carving); mahi raranga (weaving); mahi kōwhaiwhai (scroll painting on rafters); and, for our very early artists, in toi toka (rock art). These artforms utilise symbols of ritual and in-depth tribal narratives (Allingham, Personal Communication, March 2016; Flutey-Henare & Parata, 2017; Ryan, 1999; York, 2016). Not only do kaimahi toi Māori (Māori artists) carry out rituals to guide their practice, they often articulate through design and placement, depth, texture and colour the ancient symbols that provide a code for a greater bed of knowledge (Allingham, Personal Communication, March 2016; M.Flutey-Henare & R.Parata, Ngāi Tahu, kairaranga; Ryan, 1999; J.York, Ngāi Tahu, kaiwhakairo). Ngāi Tahu artists and those who are kaitiaki (guardians) of the Ngāi Tahu rock art share their thoughts about creation imagery in the next section of this chapter.

6.3 Section Three: Toi Māori

Tuhituhi o nehera (Rock Art)

Tuhituhi o nehera are ancient drawings, either painted, carved or chipped out of the surface rock, situated on cave walls and other natural shelter spaces. The South Island has over 90 percent of the known tuhituhi o nehera, and the artists of these drawings are thought to be from the very early known iwi, such as Te Rapuwai, Hāwea, and Waitaha from around the 850 AD period, with the arrival of Ngāti Māmoe and Ngāi Tahu later in the 17th Century.

Tuhituhi o nehera was practiced over a long period, according to archaeologist Brian Allingham (Personal Communication, March 2016), from the moa period through to the 19th century. The subjects within the Southern toi ana are predominantly: people, birds, dogs and waka and other unknown figures or entities. Often, spirals and chevron designs can be seen as individual drawings or within the entire illustration. Similarities are observed between the spirals and chevron designs used in whakairo (carving), kōwhaiwhai (rafter paintings), tukutuku, and tā moko (body tattoos). The spiral interpretation is discussed later in this section but the chevron design, according to Skinner (1916) and Archey (1933), articulate the limbs of a human figure and date back to a very old rectilinear period of art associated with the moa-hunter period.

All research participants above disclaimed that, although they have visited the oldest art galleries in Aotearoa for many years, they have no definitive answers as to what the art is telling the viewer or who the artists were – male, female or a younger person. As Sue Eddington (2016) from Ngāi Tahu states:

What one takes from rock art is very personal, and the fact of the matter is we do not know. I believe that it is each and everyone's perception of what they see that is their reality. Then it is just their reality. I have seen, personally, bits and pieces that to me scream whakapapa and childbirth. Yeah, it is there. It is there.

All four confirmed that, from their perspective, tuhituhi o nehera (rock art) does depict the creation kōrero. The images, whether they are humans, birds or taniwha, still show within the geometrical designs or the story they appear to be conveying, an element of genealogy and procreation. Eddington and Heath (2016) say they believe a particular tuhituhi o nehera known as “Taniwha”, located on the roof of an overhang on the Opihi River, is the creation story of Ranginui and Papatūānuku being held apart by their tamariki. There are many interpretations; another, according to Eddington, is that this image represents the three taniwha that act as kaitiaki for the tree rivers or three parts of the Opihi River (2016).

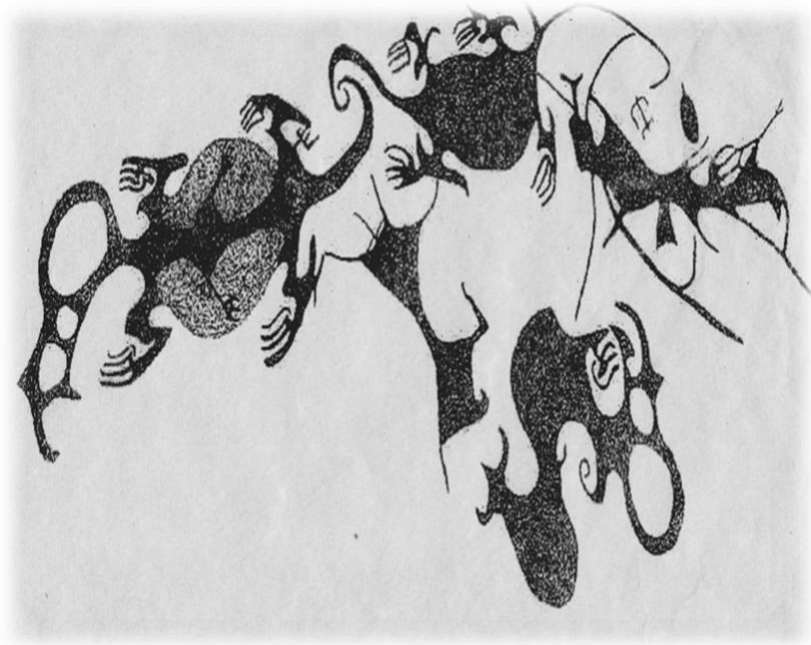


Fig 5. “Taniwha” at Opihi River. National Art Gallery Collection

Heath (2016) states there is symbolism in the spaces between lines on the tuhituhi o nehera. These spaces appear intentional to represent the void or Te Kore. Heath argues that this style of drawing reflects a prospective figure or object and that the double lines and defined space between represents the mauri (life principle) of the figure or object.



Fig 6. Figure (internal body is blank) carrying pole and bag: South Canterbury

The truth behind the drawings of tuhituhi o nehera can only now be assumed by kaitiaki (guardians), archaeologists, scientists and members of the community in which these ancient art pieces reside. However, although the artists have long since departed, the symbolism and images remain to be interpreted with the best intention of honouring the early nomadic Māori. There does, however, seem to be an agreement from the research participants who have many years of experience working with the rock art sites in the South Island that creation symbolism feature in many of the tuhituhi o nehera. Again, reiterating the importance of creation narratives and whakapapa to the wellbeing of our early Māori.

Whakairo

It is difficult to find evidence of a carving culture prior to the arrival of Europeans in the South Island. Carving fragments have been found in swamps, archaeological sites and oral narratives transmitted in waiata, karakia and pūrākau over generations. These repositories speak of the symbolism within tā moko (facial moko) or the descriptions of elaborately carved wooden weapons offered by hapū in exchange for land. The larger-sized carved arrangements, such as waka (canoes), were more evident in the later

part of the 18th and early 19th century, and these were cataloged in diaries and letters or illustrated in sketches by the early sealers and settlers (Potiki, 2015, np).

York (Ngāi Tahu/Ngā Puhi, kaiwhakairo) describes whakairo (carving) as the written language for Māori. He says it is an illustration of our pūrākau (our stories) and our whakapapa (genealogy). Every aspect, from the overall design motifs to the intricate notches, alludes to cultural identity, a genealogical narrative carved into the wood to remind the people of who they are and how they evolved. According to the historians and carvers of the University of Auckland wharehenui, Tane-nui-a-Rangi, they depicted the human figure in carvings as ancestors in the spiritual form, they had no model of reference in the physical world to assist their carving and therefore could only employ their imagination to depict what form and style these ancestors would take (University of Auckland, 1988). The knowledge that was etched into the spirals and figures, spiritually and physically unfolded into many layers of knowing from the past to the desires for the future. They were protective elements and, depending on where these symbols were placed on the whakairo (carving), for instance on a taurapa (stern post) of the waka or a door lintel, they all carried a message to those who viewed them (Allingham, Personal Communication, March 2016; Buck, 1949; Simmons 2001; J. York, Ngāi Tahu/Ngā Puhi, kaiwhakairo).

York (Ngāi Tahu/Ngā Puhi, kaiwhakairo) agrees with master taonga pūoro carver, Brian Flintoff, that motifs, such as the open spiral known as takarangi, makaurangi or pitau, and the rauru, mauī, ponahi and whakaironui as the surface spirals have evolved from the fern frond and other natural articles that were in the lives of the artists at the time they were carving (University of Auckland, 1988). All spiral symbols are said to “create the illusion of movement on static figures or to express energy or tension at various points of the sculpture” (University of Auckland, 1988, p. 19). The two intersecting spirals are said to portray the separation of Papatūānuku (Earth Mother) and Ranginui (Sky Father) in order to allow light to come into the world and the natural world to evolve. The open space between the two spirals represents this transition into Te Ao Marama (the world of light). Archey (1933) asserted that the double carved spirals are two manaia (stylised figures) interlocked at the mouth. He said that the manaia carvings are of human origin but are often carved inside the profile, giving a half-face outline, which can give a bird-like appearance. The strong reference to the creation narratives is reoccurring in Māori artforms and symbols. Acting perhaps as a

constant reinforcer of cultural identity with a reminder of creation whakapapa and as a source of strength and cultural pride (Archey, 1933; Barrow, 1956; Buck, 1949). Overall, the spiral symbolism shows a movement of potential energy that reflects creation narratives and through the use of varying depths, notches, double spirals and placement on carvings can also highlight the coming into being or enlightenment (Archey, 1977; Barrow, 1969; Mead, 1961; Simmons, 1985; University of Auckland, 1988).

Other carved patterns that are also suggestive of creation symbolism are those viewed on the tauihu (prow or figurehead) of the waka that symbolise either an atua, such as Tangaroa, or another formidable figure that issued great mana, integrity, and power. A provision of strength as the waka navigated through the moana to battle with other foreboding enemies or to seek refuge in foreign lands (Flintoff, 2004; Potiki, 2015).

Sealer John Boulton drew some of our earlier sketches of Ngāi Tahu waka in the late 1820s when he witnessed what he thought to be a waka taua (war canoe) heading to Canterbury. Carved taurapa and tauihu can be seen in his drawing and he wrote that he saw great pieces of carved wood on the waka (Boulton & Starke, 1986).

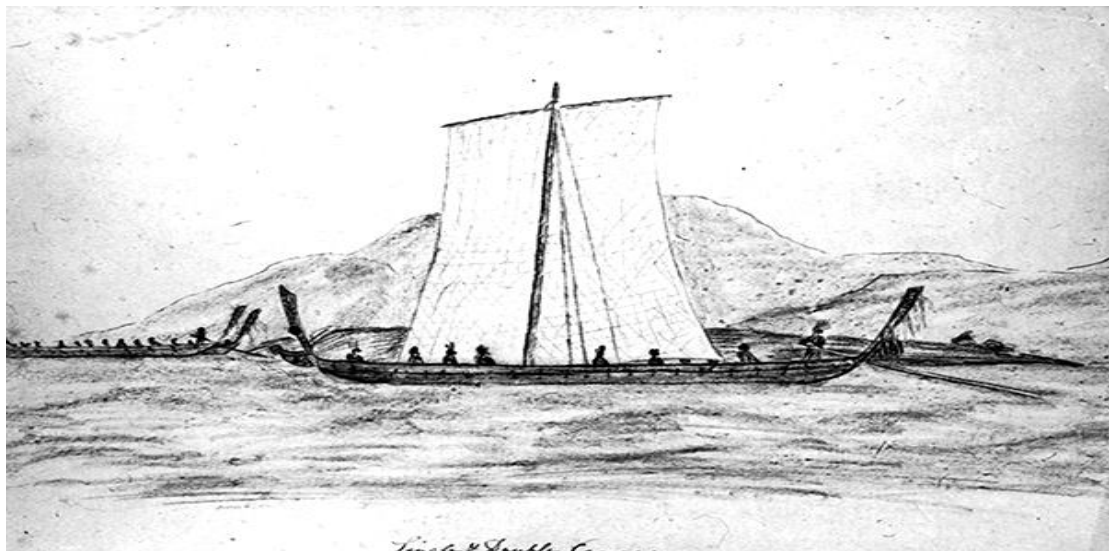


Fig 7. Pencil sketch of single and double hulled canoe. Boulton, John 1799-1854: Journal of a rambler with a sketch of his life from 1817-1834. Ref: qMS-0257-01. Alexander Turnbull Library, Wellington, New Zealand.

A recent discovery of a tauihu (waka prow) off an ancient waka in Masons Bay, Stewart Island revealed a very detailed carved prow chiseled by stone tools made pre-Europeans. The tauihu provided evidence that the earlier Te Waipounamu Māori did have a carving culture. York (Ngāi Tahu/Ngā Puhi, kaiwhakairo) believed the carving motifs on this artifact highlighted distinct carving differences unique to Ngāi Tahu.



*Fig 8. Tauihu discovered at Masons Bay, Stewart Island.
Image courtesy of the Southland Museum & Art Gallery Niho o te Taniwha*

York (Ngāi Tahu/Ngā Puhi, kaiwhakairo) says that the patterns he often associates with carving and those from Ngāi Tahu carved artifacts are the raperape (carving design). The raperape is a water motif, depicting waves and the rippling movement of water, it also emphasises evolution (see Fig 7.). The second motif York also noted can be seen on a number of Ngāi Tahu whakairo, is the taratara-a-Kai (carving design) that is a notched parallel zig-zag pattern often described as a barbed-notched pattern and seen in carvings situated on pātaka (food houses). York believes both the raperape and the taratara-a-Kai designs are often used in designs due to their reflection of survival, and their reference to fertilisation and growth (Thornton, 1989).

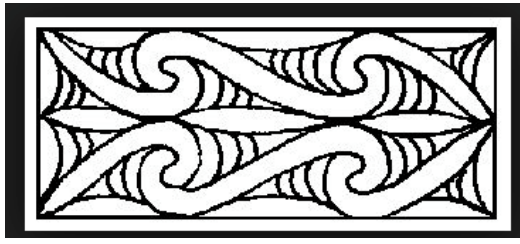


Fig 9. Raperape

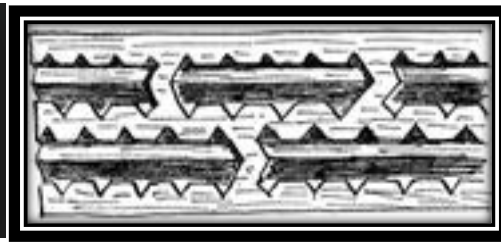


Fig 10. Taratara a Kai pattern

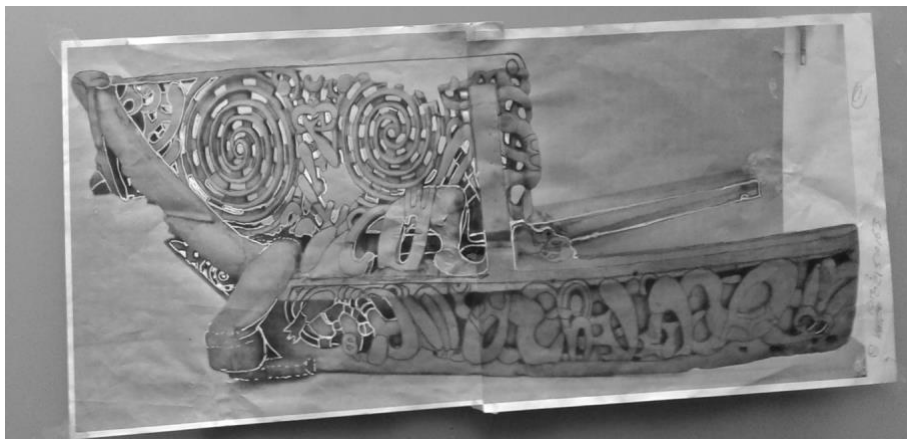


Fig 11. Tauihu on display at the Toitu Museum, Otago. Brian Allignham's drawing overtop of tauihu photo to define the imagery.

York (Ngāi Tahu/Ngā Puhi, kaiwhakairo) also discusses the stature of some of the carved figurines that are represented in the squatting position. York referenced the squatting stance of the figure(s) to be reflective of traditional birthing positions. York (2016) could not record any whakairo that illustrated a woman lying on her back to birth and therefore it could be perceived as a legacy passed down from tūpuna (ancestors) that highlighted a preferred and accepted birthing stance. A component of whakairo that perhaps displays this most strongly, is pare (door lintel), a strip of carved wood located above the door of the meeting or food house (Simmons, 2001).

Huataki or Pare Whakairo (carved door lintel)

Murihiku refers to pare as a huataki, and it carries valuable messages about a people and their founding creation philosophies. A pare is the carved piece that sits above the door of the whare tūpuna. They can also be seen above the door to the whare occupied by a rangatira (chief), and above the opening of the pātaka (food house) (Simmons, 2001). A wharenui represents the body of a renowned tupuna and would therefore be viewed as a very tapu place. Wāhine had the power to remove tapu from a man and could do this by stepping over him, this was a practice utilised when toa (warriors) returned from fighting and were in a tapu space. Wāhine would neutralise their tapu state by stepping over them. This concept was applied to the carved meetings houses by placing female figurines or symbols into the carved pare above the wharenui door. This acted as a protective factor for men leaving and entering the wharenui (Arcey, 1977; Barrow, 1969; Buck, 1949; McLintock, 1966; University of Auckland, 1988).

Pare is often described as a significant “marker” that delineates between atua domains. For instance, the outside domain of the wharenui (ancestral house) is the realm of Tūmataunga (god of war) in contrast to the inside of the wharenui being associated with Rongomatane (the god of agriculture and more peaceful activities) (Buck, 1949; Simmons, 2001). Pare also symbolise past and present and moving from the external social world to the internal whānau world. The pare has been referred to as the most tapu whakairo (sacred carving) in a meeting house due to the explicit and rich symbolism of womanhood, procreation, death, sexuality and pleasure (Neich, 1993; Barringer & Flynn, 1998).

Many pare are composed of one to three central figures, that are male, female or neuter. Some feature a number of spirals, and others have none. Some pare appear to have a sequence that express an unformed image transitioning into a more defined form (Simmons, 2001). The components of the carved pare are a symbolic portrayal of a mythical story according to Frith (1925), who claims that:

...cosmological or mythological terms of reference are reworked in the rhythms and reliefs of the pare, involved completely in each other while tending to go in the same direction (n.p).

Frith also highlights the synergy between the systems of symbols and the systems of social relations. This synergy was perhaps best explained by historian Judith Binney in 1967, when she wrote that pare are the symbolic portrayal of the universe coming into being. Pare are a condensed version of the origin myth, and the positioning of pare above the door, as mentioned previously, on the most sacred house on the Marae supports the belief that all elements of society and life are involved or founded on mythology. Professor Joseph Campbell (1974, 1988) confirms that creation myths are metaphors for life, and the study of the pare imagery with the central figurine often being female aligns itself to Campbell's research around the Universal Mother in varying stages of pregnancy and birth.

Ethnologist David Simmons (2001) says that the background of the pare indicates three states of existence: Te Kore (the state of potential); Te Pō (the state of union between Ranginui and Papatūānuku); and the birth of their children leading to the eventual separation of Ranginui and Papatūānuku. The third state describes Te Ao Marama as the place of existence or the world of light. The spiral symbolism illustrates the transition into Te Ao Marama, when pare have no takarangi (spirals) this depicts the pre-birth phase. Takarangi on pare are said to articulate that a child has been born, and therefore the central figure is a parent (Colenso, 1898, p. 29; Marsden, 1985; Williams, 1971).

Other pare subthemes are in the positioning of the hands of the central figure. The differing hand positions highlight the varying stages of gestation. Simmons observes that if the fingers of the central figure are together, this indicates a period of tapu before creation. Fingers separated represents the Io phase, and a symbol for the first twitches of life. Conception was revealed with the right hand to vulva or penis, left hand to stomach or chest, or in some pare this phase is represented by fingers of one hand in the mouth or protruding through the mouth. The right hand on the thigh and the left hand on the chest, or two hands on the body, right to the chest and left to stomach symbolise pregnancy. Labour clearly showed the central female figure squatting with hand on thigh, and one hand to the chest, and for birth and parenthood two hands were placed on the chest (2001, p. 31).

The elements on either side of the central figure can be serpent-like figures or manaia. Simmons says the manaia represent life and death principles. These figures are

metamorphic in presentation and can be seen singular, joined, animalistic in expression or have more identifiable human traits but always flanking the central figure (2011). Gilbert Archer (1933) said that the manaia were human but taken from a side profile or showing half of the human face, seeming more avian in appearance. Skinner, in his 1916 article on the *Evolution in Māori Art*, supported the bird theory, as he felt the claw-like hands with a spur where the thumb would be is highly suggestive of an avian motif. The manaia is a common motif in whakairo Māori (Māori carving) and Raymond Frith (1925) feels that the manaia reflect a “supernatural creature, a kind of atua or ancestral spirit represented by a bird or hybrid bird-man” (Firth, 1925, p. 318).

Simmons (2001) discusses further the intent of the manaia in the pare, saying that the manaia reflects two life principles, male and female, atua (gods) and ira tāngata (human life). The base plate on pare are said to represent Papatūānuku (the Earth Mother) and is a dominant presence on some pare and minimalistic on others. From the base of pare come the central figures, further emphasising Papatūānuku as the founding figure from whence forms emerge (Simmons, 2001, p. 33). Pare epitomise the valuable role women held in te iwi Māori society, their personal power to diffuse tapu and grow the next generation was highly regarded. Understanding why the pare are placed above the door of wharehau and what the pare were conveying highlights how vital the return of customary birthing practices is to ensure rituals continue to be understood and conducted as a cultural rongoā (tonic) for cultural enlightenment and wellbeing.

Tukutuku/Mahi Rāranga/Tāniko

Creation symbolism from the ancient drawings of our tūpuna emerge in all artforms, including weaving, where the term te aho mūtunga kore (unbroken thread) and te aho tapu (sacred thread) can be seen physically in the threads used in woven garments and metaphorically as the umbilical cord; a vital thread between generations and mother and child. The construction and aesthetics of woven garments also reflected motherhood and nurturing the pēpi (Ngarimu, Ngāi Tahu, Ngāti Mutunga, Kairaranga)

Tukutuku (latticework) spoke of birth, life, and death; in particular, she mentions the patterns formulated on the tukutuku panels, such as the poutama, pouhine, and the

kaokao. The pouhine (the female of poutama which is a stepped pattern seen in tukutuku), in particular, Ngarimu revealed symbolise wāhine and the whare tāngata.

Kōwhaiwhai

Kōwhaiwhai painting was traditionally a non-figurative artform that illustrated images of the natural world onto the internal roof rafters of the main meeting house (wharenui) and is also found on hoe (boat paddle). Hoe Māori (Māori waka paddles) are the oldest examples of kōwhaiwhai currently in existence. According to Roger Neich (1993), who was the Curator of Ethnology at the Auckland Museum, there are only 21 hoe Māori left in the world that have kōwhaiwhai patterns dating from pre-European times to the later 19th century. An ancient hoe featuring kōwhaiwhai in the form of five transverse bands of red oche along the blade was found in Moncks Cave in Christchurch in 1889, along with a wooden ama and a waka (canoe) bailer. These items are thought to date from the 14th century (Neich, 1993, p. 59).

The whare tupuna metaphorically represents the body of a revered ancestor and the kōwhaiwhai rafters represent the ribs of the tupuna (ancestor). The designs portrayed on kōwhaiwhai reflect the natural world as it evolves and flourishes relating to the growth of whakapapa and descent lines. Overall, the wharenui held the mauri or life principle of the people it was built for and hence it is a strong influence on the wellbeing of its members (Neich, 1993; University of Auckland, 1988).

York (2016) considers the koru as the primary pattern in most kōwhaiwhai designs. He says the koru represents growth, regeneration, and birth. Peter Buck (1938) states that the artist drew their koru inspiration from a fern frond (pitau). Flintoff (2004) adds that the koru captures the “vigor with which the frond bursts into life” (2004, p. 123).



Fig 12. Pitau (fern frond)

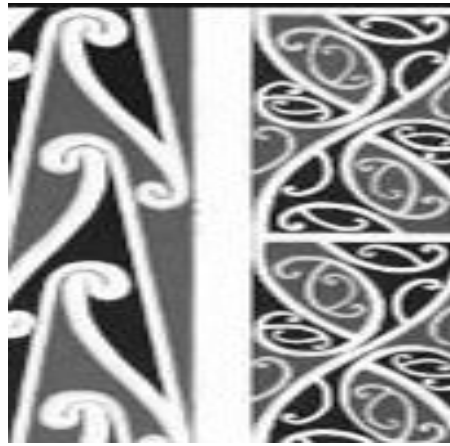


Fig 13. Koru pattern inspired by pitau

In summary, what can be gained from exploring the symbolism and placement of Māori artforms, such as tuhinga o nehera, whakairo, pare and kōwhaiwhai, is the constant expression of creation narratives clearly outlining the separation of Ranginui and Papatūānuku to allow the world of light to be seen and their atua children to grow. When this occurred, the whakapapa of humans and the natural world evolved. All the designs in Māori artforms appeared to mimic their natural world in shape, depth, combinations of designs, curves, lines, raised and shallow markings; the appearance and non-appearance told the viewer a visual narrative. The context the artist was drawing from, and what values in early Māori culture were pivotal to growth, strength, vigour and regeneration; wāhine as sacred mothers and men as protectors. To know Māori creation stories and why they were considered so important to Māori ancestors that they drew, wove, painted and carved on every artform they produced speaks highly of the extreme importance of whakapapa and keeping rituals associated with whakapapa alive to secure the survival of te iwi Māori.

6.4 Section Four: Tikanga Hapūtanga me Whānau mai (Pregnancy and Birthing Customs)

Throughout my Master's degree and during the course of preparing this thesis, regardless of the historical context or the future implications of the revitalisation of customary birthing practices, people appeared to be primarily interested in what traditional birthing practices were. They wanted to hear, see and feel the natural resources used for maternity practices and understand their context in birthing. I would often tell people that the knowledge surrounding these tikanga may have been forgotten through under-utilisation and assimilation to mainstream practices, but the natural resources still exist and are obtainable. The following are examples of accessible resources and how they were employed in pregnancy and birth.

Rongoā (traditional medicines) with pregnancy and birthing rituals

Awareness of the medicinal properties within the living resources around the kaik (village) or temporary noho puna (temporary camp) was paramount for wellbeing and, ultimately, survival for te iwi Ngāi Tahu. Most Māori had general awareness around extraction from plants and trees alongside other medicines that could be harvested from animals for medicinal usage but there were also experts situated in iwi and hapū that others would seek out for more intensive health issues. Rongoā was synonymous with ritualistic practice and when combined they gave greater potency to the task at hand. Rongoā represented the natural world and karakia called upon the differing deities in respect to the presenting concern or desire.

Authors Riley (1994) and Taiatini and Jones (2009) praised Māori for their intimate understanding of plants and animal byproducts that have medicinal properties, and how to effectively and safely prepare and administer them. Rongoā were ingested, applied topically or in a poultice, inhaled as a vapour and supplied when required throughout the maternity process from conception, pregnancy and birth. Karakia provided the spiritual platform to commence the application of rongoā. Natural medicines, such as the yauhtli herb and flowers, were used in Mexican Indian purification ceremonies

(limpías) and to dilate the cervix in labour. Tobacco has been used for a long time in Mexico as a relaxant and to provide energy for the woman tired and overwhelmed by her labour (Gonzales, 2012). Herbal medicines were also used by First Nations and Inuit people throughout pregnancy and birth. The older Indigenous First Nations and Inuit midwives who carry this medicinal specialty are passing away before their wisdom can be passed on (Benoit, 2001; Birch et al., 2009).

In terms of commonly noted rongoā Māori for hapūtanga and birth, the following are mentioned in the literature and from oral accounts:

Karamū (*coprosma robusta*) leaves and bark were used in ceremonial rituals over the wāhine wanting to enhance their fertility chances and to encourage the gender of the child to be a male. The karamū branch would be held on and over the wāhine while karakia were performed. Karamū was also used as a body purifier when inflicted with consumption and other illnesses (Beattie, 1994; Best, 1975).

Kawakawa leaves (*macropiper excusum*) could be infused in water or oil and the liquid ingested. Alternatively, it was dropped into the water that the wāhine would sit in to assist with whenua (placenta) expulsion or applied topically to the vagina and perineum area to soothe and heal following birth (Taiatini, 2011).

Harakeke (*phormium tenax*) leaves were stripped to reveal their inner fibre; the fibre was rolled into whītau muka or cords to tie the iho (umbilical cord). One strip of whītau muka would be used at the base of the pito by the baby's stomach and another about 5-8cms away; the iho would then be cut in between the two whītau muka.

The butt of the harakeke leaves could be crushed and made into a poultice that was then applied to the vagina and perineum area for pain relief and to aid healing. The harakeke roots could also be crushed and made into a drinkable substance that would be used as a powerful bowel stimulant. Stimulation of the bowels also encourages the peristalsis of the uterus in labour and harakeke was also used post birth to facilitate the discharge of the whenua (afterbirth). The lower part of the raupo stem (bullrush) was used in the same way; roasted in the ashes of the fire, the inner white core can be eaten to produce the same results (Beattie, 1994; Bell, 1990; Best, 1975; Hopkinson, 1990; Thompson, 1990).

Another popular plant was the kopakopa (*plantago major* or plantain). The leaves of this plant were used to draw the infection or poisons from the wound or origin to reduce inflammation and heal the injury. Post birth, the kopakopa leaves were warmed and placed on the mother's vagina for pain relief, and the leaves with sow thistle could be boiled together and ingested as a uterus stimulant to aid whenua (placenta) expulsion. Rima Bell also remembered the widespread use of the kopakopa plant in the Tūāhiwi area (Dacker, 1980). Maere Burns of Ōtākou remembers the koromiko (*hebe salicifolia*) being used to treat diarrhoea and the leaves could be inserted or placed near the vagina to coagulate the blood if the wāhine (woman) was hemorrhaging post birth (Dacker, 1980; Ngāti Koata Trust, 2017; Riley, 1994).

Taua Naina Russell from Ruapuke Island (southernmost Island, southeast of Bluff on the Southern coast) remembered using the water from boiled kaio (*myoporum laetum*) leaves to clean wounds, or as a poultice to be soaked in the water before applying to the wound (Dacker, 1980; Riley, 1994; Williams, 1996).

Various tree barks, such as the aka vine or kōwhai (*sophora tetraptera*), if steeped in water (waikōwhai) for a long time, release medicinal components into the wai (water). The wai could then be applied to cuts and wounds, such as those inflicted during birth (Beattie, 1994).

Rongoā was also collected from the sea to aid the labour and post-natal phase; Makareti Papakura (1983), Riley (1994) and Taiatini (2009) discuss the nourishment in the pipi or fish broth. Boiling pipi or other forms of molluscs and mohi (sea fish) produced a salty tonic high in calcium, iron, magnesium, sodium, potassium, zinc and copper. These brews were given to provide energy during labour and to reduce vaginal bleeding post birth. Beattie (1994) wrote that babies were given pipi or kūtai to suck on if not settling. Neta Hopkinson mentioned that rimurapa (kelp or seaweed), when cut from the thick stem close to the root and boiled, tasted like sweet liquorice and was used to stimulate the bowel. Bowel stimulants were an option to activate the uterus to induce labour (Dacker, 1980).

Animal and seed oils were also commonly used independently or as a medium to carry and apply other medicinal treatments. Oils could be ingested or secreted onto hot rocks or into boiling water to create healing vapours. Seed oils were also applied to the severed umbilical cord to promote fast and optimum healing (Jones, 2009; Murdoch

and Bendle, 2018; Riley, 1994). Kekenō (seal) and bird oils were noted in Janet Taiatini's *Rongoā for Maternity Purposes* paper (2011). These oils were dripped into the mouths of newborns, which helped clean out their intestinal track post-birth by acting as a bowel stimulant (Beattie, 1994). Beattie (1994) also wrote that motu-pakake was the name given to kekenō hinu (seal /fat) and given to babies before their first breastmilk feed. Motu-pakake was considered by Māori to be good general medicine and could also be cooked and given to a baby or young child (1994). In the Murihiku area, it was noted how useful weka oil was for reducing inflammation and swift healing. Jimmy Bragg from Murihiku remembered the use of weka oil and the oil from young tītī called ruakakata, primarily for rheumatics but also for other inflammatory complaints and discomforts such as those that occur through the birthing process (Dacker, 1980). Mirimiri (massage) was also given alongside karakia or waiata and bird oils were used as a lubricant to aid the kneading of the skin (McLean, 2011; Stone, 2011; Taiatini, 2011).

Mirimiri

Ruahine (elderly wāhine) would often use mirimiri in conjunction with karakia; while mirimiri worked the physical realm of the body, the karakia worked the spiritual by evoking the atua (god) to protect the foetus as it developed in the whare tāngata (womb). The ruahine were ever watchful of any ill omens caused through mākuṭu (black magic) that may be inflicted upon the mother, child or whānau. The ruahine's role was to detect any changes to the wairua (spiritual), mauri (life principle) and physical condition of the wāhine hapū and act immediately to rectify them (Gillies, 2011; Gray, 2010).

Mirimiri and romiromi (another form of massage) could be applied to the breasts, uterus, back, legs, buttocks, perineum, inner thighs, arms and the head to release tension, direct pain out of the body, encourage the opening of the cervix and to physically assist the movement of the baby down the birth canal with gentle manipulation on contraction. Pressure applied to the top of the head by the hand of the birth attendant at the commencement of contractions was also noted in the literature as another useful practice throughout troublesome labour (Harte, 2011; Ngarimu-

Cameron, 2011; Taiatini, 2009). Meri Crofts shared that, when she was born in 1942, she had mirimiri to her legs by her elders at Koukourarata when she was a pēpi. The intention of the mirimiri was to give Meri great shaped legs, although Meri begged to differ and said she had the worst shaped legs in the whānau. However, Meri confirmed that mirimiri was a practice amongst the aunties at Koukourarata with the hapū wāhine and pēpi (Crofts, 2018).

Rongoā is not a singular practice but a collaboration of many resources and applications for the best health outcome. Rongoā represents the natural world while karakia incite the spiritual realm to strengthen the potency of the rongoā (Jones, 2009; Murdoch and Bendle, 2018; Riley, 1994). Another, form of rongoā is wai (water) from the sea, rivers, ponds or streams.

Wai (water)

Wai was a sensory tool used in sound to aid the labouring woman to use the energy produced in the gush of water from waterfalls, streams and seas to gain a helpful rhythm to breathe through the contractions. The buoyancy, current and healing minerals in water were also taken advantage of during labour. Women would lie in the water to aid muscle relaxation, to aid flotation of their body and to birth. Makareti Papakura (1938), Lilian Stirling (Ngāti Porou, Te Whanau ā Āpanui, kaumātua) and Rik Pitama (Ngāi Tahu, kaumātua) referred to births taking place in water. Stirling specifically referred to birthing on the seashore; she spoke of the utilisation of the moon and the tide to capture the lunar pulling movement to help mothers direct their focus and energy to push their babies down the birth canal.

Other stories mentioned rock pools, waterfalls and streams near the Marae as areas where birth took place in or near the water. Water was also used in the removal of the whenua (afterbirth); the water provided relief and energy to help the mother go through the final stages of birth. It was vitally important to the mother and those attending to her that all of the whenua was removed from her uterus to avoid post-birth infection and hemorrhaging (Best, 1929; Makareti, 1938; Pitama, Ngāi Tahu, kaumātua). Another practice to remove congealed blood from the uterus post birth is to produce a

tapū māmāoa (vapour bath). Laurie Gluckman (1976) gathered an array of writings concerning New Zealand's medical past before 1860 and dedicated a chapter in his book, *Medical History of New Zealand*, prior to the emergence of obstetrics and paediatrics. Gluckman mentioned the vapour baths created by heating stones and using combinations of herbs and plants that a wāhine post birth would sit upon to promote lochia discharge

Ūkaipo (breastfeeding) is the action to give waiū (breastmilk) to the newborn. It was also considered as a rongoā that provided the child important nutrients and comfort for the first stage of their lives.

Ūkaipō (Breastfeeding)

Breastfeeding was a way of traditional life, a learned experience that was passed down from grandmother, to mother, to a new mother. Nipples were prepared as soon as wāhine were hapū (pregnant). This was done through rubbing or pinching of the nipples to harden them and mirimiri (massage) of the nipple and breast area. Meri Crofts, a tāua from Tūāhiwi and Koukourarata, said her grandmother tried to dissuade the wāhine at the pā to take up bottle feeding. Meri (2018) said she was a staunch advocate for breastfeeding as the first food for pēpi. Reports of the duration that wāhine breastfed their pēpi range widely. Taua Minnie Thomas from Waihao said that the majority of wāhine at Waihao breastfed their pēpi up till six months of age (Dacker, 1980). Born in 1904, Naina Russell remarked that on Ruapuke Island, where she lived with her husband and their six tamariki, that all the wāhine fully breastfed their pēpi until approximately three months of age, and started to wean them at nine months (Dacker, 1980). In Kaiapo, North Canterbury, Neta Hopkinson remembers when she was a young mother that breastfeeding was encouraged for a long time, well after the pēpi could walk (Dacker, 1980). Atholl Anderson (1998) found evidence that suggested some wāhine even breastfed up to four years of age and older. When the introduction of solids took place, the foods commonly reported were sweet potato and the flesh of young birds chewed by the parent before being fed to the baby.

Rongoā, such as kohekohe (*dysoxylum spectabile*), could be ingested to reduce milk flow to assist in the weaning process (Taiatini, 2011). Wet nurses were not uncommon within iwi Māori and other members of the whānau would take on the breastfeeding of a child if the mother could not breastfeed them herself (Best, 1975; Beattie, 1994, Glover & Waldron, 2011). Breastfeeding became a “lifestyle choice” when legislation like the Infants Act in 1908 restricted the ability of Māori women to whāngai-ū (breastfeed another whānau members child) for longer than seven consecutive days unless they formalised the arrangement through law. The Native Land Act in 1909 stopped the concept of whāinga-ū altogether and these directly had an impact on Māori wet nursing and/or parenting of other whānau children (Glover & Waldon, 2011; Mead, 2003).

Western practices were introduced, such as feeding babies diluted cow’s milk, oatmeal diluted in water, barley water, and other milk substitutes, often with sugar added. Infant services, such as the Plunket Society founded in 1907 in Dunedin by Frederic Truby King, initially promoted breastfeeding to mothers of babies failing to thrive. King’s Plunket Society set such strict breastfeeding regimes at this time that these regimes clashed with how Māori preferred to breastfeed, which was on-demand (Dow, 1995, 1999; Glover & Manaera-Biddle, 2007; Chapman, 2003).

King still supported breastfeeding but also accepted the need by some families for additional formula and with his entrepreneurial skills he developed and marketed “humanised milk”, a product from cow’s milk and produced it under the label Karitane Products Society in the 1920s (Chapman, 2003; Dacker, 1980). Influenced by the overseas trends of the mid-1880s, bottle-feeding became more fashionable and this led to artificial formula being produced commercially; all women, including Māori, were encouraged to bottle feed their babies (Clark, 2011; Dalley, 2004).

Tukanga whānautanga (Birthing Positions)

In the book, *Traditional Lifeways of the Southern Māori*, Herries Beattie’s (1994) informants associated the celebrated ancestor Tura as one of the earlier ancestors of the Southern whakapapa. His name was included into a cry of pain often heard by women

at the peak of their birth, “Taukiri e Tura”. Taukiri, says Beattie’s Southern informants, is used to express an element of surprise or alarm and is historically rooted in Tura’s love for his wife who heralds from Rapuwai or Maeroero. Her tribe believed that babies were to be born by opening up the stomachs of the mothers and consequently killing the woman in the process as a sacrifice for her newborn. Tura did not want to lose his wife in childbirth, so he hid her away from the old women and held her through her labour and consequent birth. Her cry of “Taukiri e Tura” was her cry of surprise and pain as she birthed her baby naturally.

The way that Tura positioned himself around his wife as she birthed became a birth position utilised by other birth attendants. The wāhine and her assistant would crouch down on their heels facing each other. The assistant would wrap her arms around the back of the wāhine hapū and press her knees into the sides of the wāhine hapū’s puku (belly) upon contractions, and this pressure was intended to aid the pēpi down the birth canal (Hunt, 1952; Jeffery, 2005; Stone, 2011).

Ngāi Tahu midwife Herena Stone (2011) mentioned Māori birth positions, which were also noted by Christine Jeffery (2005) in her report on the experiences of Māori women who gave birth at National Women’s Hospitals between 1958 and 2004, as well as in an unpublished thesis for Otago Medical School by Hunt in 1952 about Māori maternity in the Waitomo County. They all described a specific birthing position utilised most often by Māori, which was the squatting position either on their knees or feet. Another position less frequently mentioned, was the side birthing position where the wāhine would lie on her side with her top leg bent and drawn tightly to her stomach and her top arm supporting her upper body (Hudson 2011; Mihaere, 2011).

Women birthing alone would use the branches of trees or a digging stick to rest upon or to create resistance to either manually push the top of their uterus against or to push out the pain during contractions. Leah Wineera of Taumutu and Ōtēpoti was born in 1900 and recalls squatting on the floor to have her pēpi. The Māori nurses supported her by rubbing firmly in a downward motion on her uterus to aid the labour process and eventual birth. Naina Russell from Ruapuke Island concurred that this was also the favoured position of birth on the Island (Dacker, 1980).

Erihapeti Rehu Murchie from Arowhenua held multiple public roles over her lifetime within education and health. She was the President of the Māori Women’s Welfare

League between 1977-1980, and she served on the Human Rights Commission from 1988-1995 and then stayed on in a kaumātua capacity for the Commission until her death in 1997. Murchie worked tirelessly to improve New Zealand human relations and to improve public health, particularly whānau health and wellbeing. When Murchie was interviewed about her birth, she told interviewer Bill Dacker that she was born prematurely at home. She recollected that her mother birthed with no attendants and Murchie seemed to think there might have been complications with her mother's pregnancy and labour that led to her premature birth. Murchie indicated in the interview that perhaps her mother should not have been working and this could have been the cause of her premature labour and consequent birth. Murchie also hinted that the place of birth within the house could have also been because the difficulty was cast over the birth and Murchie indicated in her kōrero this was not the usual place the babies would be birthed in the whare. However, Murchie did survive and she was the last to be born at home in 1923, her other whānau members were born in the hospital.

Murchie said that the local Māori doctor named Sconnel, was a highly regarded person her community. He encouraged Māori to go into hospital for their births. He utilised Murchie's mother, Oriwia Hawea to help him when he attended to patients at the Arowhenua Pā. Oriwia Hawea was a known practitioner in rongoā (Māori medicines) and a member of the Ratana Church. Part of Oriwia's duties to the Church was to assist the sick. Murchie indicated that Oriwa was a great help to Doctor Sconnel, not only for the care she provided but her ability to kōrero Māori. It was also noted in this interview that the elders at this time (circa the 1920s) acknowledged that the transition from the home to the hospital for birth meant a movement away from Māori childbirth practices. Specifically noted, was the refusal in hospital to allow Māori to squat down to birth. They were told to lie on a hospital bed to birth, as this was the approved birth position in the hospital. Murchie said the elders accepted this as the "Pākehā way".

Oriwa attended many whānau births and to those unwell; it was not uncommon that many of the mothers in the kaika (villages) became known as the lay midwives in the area due to experience gained from attending multiple births over many years and learning from those who birthed pēpi before them (Dacker, 1980).

Wahi Whānaungatanga (Birthing Locations)

Birthing locations varied amongst the iwi, but mostly in Te Waipounamu wāhine took themselves, and sometimes their attendees, to birth away from their whare and the kaika (Māori village). Often birthing near a river, stream, sea, and for some hapū this would be a designated birthing area identified by a known rock or tree that generations of wāhine had birthed beside. Rapaki elders remember wāhine hapū going to a waterfall and the local stream to birth, similar to the stories of Moeraki of wāhine birthing near the Moeraki boulders in a dedicated area. Others remember stories of their tāua when younger walking a short distance from the kaika and returning so many hours with a pēpi in their arms (Pitama, 2011; Tikao, 2010; Wesley, 2014).

Te Whare Kōhanga (The Birthing House)

The use of the whare kōhanga appears to be a northern birthing practice for high-ranking wāhine predominantly. These wāhine endured greater birthing restrictions and rituals to protect the mother and unborn child. The whare kōhanga (nesting house) was visited in the last two weeks of the hapūtanga (pregnancy) and the hapū wāhine (pregnant woman) would have the full-time attendance of tapuhi (birth assistants) to nurse them (Best, 1975; Pereme, 2011).

Once the birth had taken place in the whare kōhanga, the wāhine and child remained in this whare until the coming away of the pito (the stump of the umbilical cord). This was a symbolic gesture indicating it was time for the child and mother to return to join the people of the kainga (village) and present the mother and child to the whānau whānui (wider family) and hapū (subtribe) (Pereme, 2011; Stewart & Tait, 1951; Stone, 2011).

The whare kōhanga appeared to vary in appearance and construction; some Northern constructions were recorded as more robust and formalised structures, whereas others appeared in the literature to be temporary in design and protection (Best, 1929; Heuer, 1974; Makareti, 1938; Stewart & Tait, 1951). Binney and Chaplin (1986) described some of the whare kōhanga as tents.

Robert McNab from Invercargill published in 1907 *Murihiku and the Southern Islands from 1770 – 1829*. Jane Davis of Murihiku highlighted a passage in McNab's book under the chapter titled *The Natives 1823*, about a birthing hut.

When a native falls ill, or a woman is about to bear a child, a small hut is built specially, a few fathoms away from the other houses; it is set on fire when it is no longer occupied (McNab, 1907, p. 326).

Once the mother, pēpi and her entourage had left the whare kōhanga, it would be burnt down to remove the tapu of birth yet the site of the whare kōhanga would always remain symbolic of the tapu status that occurs with high-ranking births (Heuer, 1972; Papps and Ollsen, 1997).

When Māori moved from rural to urban dwellings in the 20th century, a room in a house was cleared and dedicated to the birthing process in remembrance and acknowledgment of traditions. This room would consist of a bed for the mother, a stool for the mother to lie over with her abdomen on the edge of the stool so that on contraction the stool supplied further pressure to her uterus. A sack with a clean sheet would also be in the room to birth the baby upon, some clothing and a wash tin to clean both the mother and baby post birth. This room was considered tapu, as was a whare kōhanga and only cleared of its tapu post birth with the appropriate karakia (Coney, 1993; McLean, 2011; Murchie in Dacker, 1999).

Pito (part of the umbilical cord near the belly of the baby)

The pito is a term used to describe the umbilical cord nearest the pēpi's naval, post severance from the whenua (placenta) at birth. Maripi (knives) were crafted to cut the iho from shells, such as pipi or kūtai, and tuhua (obsidian flakes) were another cutting tool often kept for just this purpose. Hirini Mead (2003) describes the part of the umbilical cord nearest the whenua (placenta) as the rauru and the entire umbilical cord was called the iho (umbilical cord). The pito takes less than a week to dry and dislodge from the pēpi. There are many repositories for the pito depending on hapū tradition. Some are buried with the whenua (placenta), others are placed in tree crevices, rock

clefts, within pou (posts) that mark hapū boundaries, other pito are placed in holes drilled into a stone and then sealed, some are kept and buried with a significant whānau member at their tangi (Best, 1975; Kani, 2011; Makareti, 1938; Mead, 2016).

It has also been noted that high-ranking births may have placed the pito in a stone box and deposited near the tūāhu (sacred alter) (Riley, 1994). The pito was acknowledged and honoured for the role it played in connecting the mother and pēpi in utero during gestation. The pito is a tohu of this mother/child union and honouring the pito is honouring the sacredness of conception and birth. Placing the pito in prescribed locations on iwi whenua (tribal lands) continues to link the child to their tribal land and their whakapapa (Aumua, 2011; Best, 1975; Kani, 2011; Wepa & Te Huia, 2006). Ngāi Tahu stories speak of pito being placed inside the tīkouka frond of the tree. A living example of this remains in Kaikoura, where a tī kouka tree holds the pito of many generations of Ngāti Kuri. Another kōrero from Koukourarata (Port Levy) speaks of the pito being gifted to the waitapu (sacred waters) where the tohi (purification ritual) was conducted (Manawatu, Personal Communication, February 2016; Gillies, 2011).

Another important customary birthing practice is the burial of the whenua (afterbirth/placenta) this practice has perhaps seen the strongest reclamation over the last five years, and appears to be more widely known and taken up by many cultures in New Zealand. The following segment discusses this in greater detail.

Tāpuke Whenua (Placenta Burial)

All readings on whenua burial by historians Herries Beattie (1990), Elsdon Best (1975) and Te Arawa anthropologist Makareti Papakura (1938) who wrote her thesis that eventuated into the book titled, *The old-time Māori*, emphasised the importance of the whenua burial ritual. They all acknowledged the sustenance both the placenta (whenua) and land (whenua) for nurturing the growth of tāngata whenua. The whenua could be planted, near a sacred area, deposited into a tree or cave to enable both the mana and the mauri of the baby to remain intact and to cement the child's whakapapa to their hapū, iwi and whenua (land). The desire of connecting people to the land perhaps is to reinforce a unity with the land so one will protect and sustain the other in order for both

to survive. Ruavilla Moeroa (aka Mickey Johansen) of Ōtākou remembers her mother referring to the whenua being buried under a tree near where the baby was born (Dacker, 1980).

Minnie Thomas (92) from Waihao spent her later years in Timaru and told historian Bill Dacker that she remembered the whenua of the pēpi being taken and buried under a big macrocarpa tree. She thought that each whānau had their custom around the burial of whenua during her time. Minnie and her six other siblings were all born at home, but Minnie's children were born in the maternity wing of Waimate Hospital (Dacker, 1980).

The whenua would be taken before the next dawn and buried at sunrise. According to one of Beattie's Murihiku informants, sunrise was the most favourable time as he claimed the sun became stronger towards the zenith point of the day this potency was then shared via the whenua to the child. The beginning of twilight to daylight is indicative of good energy and astronomical alignment between night and day was imparted to the newborn to bless them with a healthy and prosperous future (1994).

One of the fears held by mothers birthing in hospitals post the 1920s was that hospital workers would take their child's whenua away and place in the incinerator, as this was standard hospital practice post birth at that time. Teone Tikao said that the burning of whenua by Pākehā doctors and nurses went against the lore of mana (integrity/prestige) and doing so destroyed the mauri (life principle) of the pēpi. Therefore, in order to preserve the mana and mauri of the pēpi it was culturally correct to bury the whenua (Beattie, 1990).

He kaitiaki (a protective guardian)

Kaitiaki is the tikanga of gifting a kaitiaki to protect the pēpi. Kaitiaki can be in the form of an animal, person or environmental phenomenon that appeared or had a presence during labour, birth or post birth or throughout the gestation period. The kaitiaki can be what the whānau or those attending the birth noticed or is known to the whānau. The kaitiaki will be acknowledged in either the naming of the child or is dedicated as the child's kaitiaki. For the whānau Ruru, their kaitiaki is not one that comes during birth but is associated with their name. Meri Crofts (Ngāi Tahu, kaumātua) on her maternal side comes from the whānau Ruru, and for this whānau the brown ruru (owl) is seen as their whānau kaitiaki. Meri made a clear distinction that the brown ruru, not the white ruru, is the better omen for her whānau. The white ruru signifies terrible luck for the newborn, whereas the brown owl was a more favourable omen.

Te Rite Tūā (naming ceremony)

The naming of a child was an important ritual within Māoridom and the name itself would reflect a significant event or connection between hapū and iwi. Ranginui Walker defended the value of Māori names when he said:

Personal and place names were of functional significance in pre: literate Māori society as the fixed points of reference for orally transmitted traditions they were the tangible markers of tradition. Proper names were a reminder of the past and constituted guides to future actions (1969, p. 405).

Māori have applied proper names to sacred cosmological events and phenomena of nature. They have arranged them in sequences and recited them in a similar way they would recite their whakapapa (family lineage). Proper names are evident in the naming of the creation whakapapa, by placing a definite article such as Te converts a common name to a proper name, Kore becomes Te Kore and Pō becomes Te Pō. The naming of children after ancestors, landmarks or significant events served as memory holders in the history of that child and their whānau (Buck, 1949; Walker, 1969).

Colonisation and the influence of the missionaries in the 19th century saw the quick uptake of Christian names, such as Hohepa, Ripeka and Matiu, and those born post World War Two had names reflecting the places their whānau member spent time at, for example Crete, Allies, Cassino and Alamein (Barlow, 1991; Bay of Plenty Beacon, 1943; Beatties, 1994; Mead, 2003; Walker, 1969).

6.5 Section Five: Ngāi Tahu Kaiwhakawhānau

Throughout the literature research and the stories shared by the research participants, it became evident that these early district nurses and lay midwives played a significant role in their community, and within their whānau. They appeared to be able to attend to all manner of health issues, travelling long distances and over compromising terrain to attend to whānau in more remote locations. They were strong bastions in their pā, kaika and towns. Therefore, it is worthy to share their names and honour their mahi (work), like a karakia or a waiata, to ensure the legacy of their mahi endures.

While legislation changes were taking place regarding health throughout the 20th century, life at the pā carried on as best as it could. Knowledge gleaned for this chapter from literature, participants, and interviews conducted by Otago historian Bill Dackers in the 1980s with Māori elders in the Canterbury and Ōtākou area enabled some of the names of those hardworking midwives and birth attendees to be acknowledged. Recollections of the kaimahi and their work act as a reminder that, regardless of the legal restrictions placed upon traditional birthing practices, Māori continued to produce babies and for a long time Māori continued to care for their own using the techniques adapted from those before them (Dacker, 1980). The narratives in this section highlight that rural Māori communities sustained customary birthing practices longer than those closer to the main centres. This is perhaps due to preference and necessity; with reduced access to medical services hapū members continued to assist with birth and attend to the ill. They were also less likely to be immediately influenced by legislation that coerced Māori women to birth away from their community and accept the care of the registered midwives and physicians (Gulliland & Pairman, 2010; Heuer, 1972; Jenkins et al., 2011; Lange, 1999).

Koa Mantel Kean (Moeraki) remembered the stories of her taua (grandmother) Mere Peti birthing 21 babies yet only seven survived. Kean understood through whānau kōrero (family discussion) they were buried in the reserve by the southern boundary lines at Moeraki. Barney Porete (Pollett), who was born in the 1860s, was also mentioned by Koa and by taua Vivienne Leonard, who was a midwife herself, that Poua Barney brought many of the local Moeraki pēpi into the world. He encouraged the

wāhine to birth kneeling or crouching on the floor and dismissed the bed as an option (2011).

On the isolated islands of Wharekauri (Chatham Islands), situated 870km southeast of New Zealand, the locals took charge of their maternity care. Airini Grennell was born in 1910 in her home at Matarakau on Wharekauri. She shared with historian Bill Dacker that many women and men on the Island carried the skill of birthing babies as a matter of practicality. Airini recollected a lay midwife who would be called upon from Rapaki Marae in Lyttleton to come and birth the babies, and that was her Aunty Raukura Tikao (also known as Aunty Fan Gillies). However, this was never easy, as Raukura spent many times held up on the boat just out from Wharekauri waiting for conditions to settle before reaching Wharekauri, to find the pēpi had been born. Also, in 1918 influenza struck Rapaki far worse than Wharekauri and Raukura was kept busy looking after the inflicted who lay in the makeshift hospital in the old hall, now the Whare Tūpuna Wheke at Rapaki. The men of Wharekauri were then called upon to assist labouring mothers, and many continued in this role. Airini recalls an incident where her father Henry, helped deliver a baby on his boat while he was ferrying the expectant mother to Lyttleton, enroute to the maternity ward (Dacker, 1980).

Elizabeth Cunningham of Koukourarata remembers Airini's father and her grandfather. Henry was affectionately known as "Da" and was born in 1885 at Wharekauri. He eventually left the Island and farmed on the mainland, but after marrying Mary Tikao they decided to return to Wharekauri and settle at Owenga in the early 1900s. Henry and Mary had five tamariki (children), Henry delivered the first four, and their whānauka (relative) Raukura delivered the fifth (Cunningham, Personal Communication, January, 2018; Dacker, 1980).

Being a farmer, Henry used his knowledge of animal husbandry to assist his wife Mary during the births of their tamariki. He buried the whenua of each child under a particular tree along with a piece of pounamu. Henry later told his Koukourarata whānauka that what worried him the most while delivering the babies was leaving his wife in pain. However, he said, she never complained (Cunningham, Personal Communication, January 2018; Dacker, 1980).

Elizabeth said when she lived at Wharekauri from the late 1960s to 1973, the Catholic nuns at Wharekauri looked after the pregnant mothers. If there were complications, they

would travel to New Zealand. Elizabeth remembered the sense of isolation and loneliness the mothers felt when they traveled away from Wharekauri and whānau to have their pēpi (Cunningham, Personal Communication, January 2018).

Naina Russell from Ruapuke Island was born in 1904, her husband and her aunty birthed her three children. Many Island whānau did not have access to regular maternity services or practitioners. Therefore, it became a necessity that the husbands or nearest relative took over these duties. There are many stories from the Wharekauri (Chatham Islands) and Ruapuke Islands that confirm that males were midwives and were often relied upon to do this mahi (work) (Dacker, 1980; Cunningham, Personal Communication, January 2018). Rima Bell of Tūāhiwi told interviewer/historian Bill Dacker that she was familiar with women birthing their babies by themselves and having the confidence and competence to do so; in reflecting upon Rima's narrative, it normalised birth as an everyday experience that if a woman was well and able she could, and historically she did, birth her babies (Dacker, 1980).

Rima spoke of a Mrs Crofts as the midwife for Tūāhiwi, and Rima's mother also birthed many babies in the community. On many occasions, Rima as a young child would help her mother at births by attending to the fire, boiling the water for the sterilisation of the cotton and scissors. Rima spoke highly of the skill that the local Māori midwives had, including her mother, as there were no infant or maternal deaths in her memory of the births she attended alongside her mother (Dacker, 1980).

Pere Tainui and Waitai Tikao (2019) spoke of Amiria Puhirere of Ōnuku in Akaroa. She was known as their local midwife. Tainui described how Amiria would assist the birth by placing her knee on top of the labouring wāhine's stomach to apply gentle pressure to aid the pēpi's journey down the birth canal. He shared that the kaik stories remarked on the screaming of the expectant mother echoing out over Ōnuku. Puhirere was also known for extreme endeavours to assist whānau to have their pēpi. She would swim from Ōnawe across the harbour with her clothes and necessary items above her head. Puhirere was said to be strong, six feet tall and with distinctive hands "twice the size of men", recalls Tainui (Personal Communication, 2019). Announcing a birth in Akaroa to neighbouring hapū and Marae around the Peninsula was achieved by lighting a fire. Fire up high on the hill denoted death, if lit further down the hill indicated birth (Tikao, Personal Communication, 2019).

Lucy Ann Harwood of Ōtākou was born in 1890, and she remembered a Mrs W. Ward, who was a Māori midwife in the area, and she delivered babies for both Māori and Pākehā wāhine. Bill Dacker interviewed Leah Wineera in 1985, she was 85 years of age and from Taumutu, and she told Bill that her mother died giving birth to her youngest sister Bessie at Ōtākou. As for Leah's births, she delivered five of her sixteen children at home, and she had the assistance of Māori nurses who would rub her stomach in a downward motion. Leah did remember being aware of the Māori nurses being apprehensive of the Pākehā doctors and whether they would approve of their practices when they visited their mothers post birth. Leah said that the Māori nurses did not need to fear, as the doctors always approved of the Māori nurses that led to healthy births (Dacker, 1985).

Ruavilla Moeroa (aka Mickey Johansen), also of Ōtākou, spoke of her mother attending births in the Ōtākou area alongside her Aunty Jenny or Emma Worscott (unsure if the same person or two sisters). They would travel on horseback to whānau in the area and if a doctor were required, they would send someone on horse to the post office in Port Chalmers to get hold of the local doctor. Ruavilla claimed that all the women she knew who attended birth were also the ones who washed the tūpapakū (dead) in preparation for their tangihanga (funeral). This was commonly spoken about in many Ngāi Tahu hapū areas. The role was dual for both attending to birth and those who had passed (Dacker, 1980).

Merci Henry of Arowhenua was 75 years of age when Bill Dacker interviewed her between 1986 and 1989. Merci was born in 1915; her mother was a midwife for her whānau whānau (extended whānau), likewise other Māori mothers in the area all appeared to have the skills to deliver babies. Merci commented that the local doctor was impressed with the hygiene techniques undertaken at the home births (Dacker, 1980).

Neta Hopkinson was 75 when Bill met with her and her husband, Ray. Neta was born at Riverton, then moved to Taieri and eventually shifted to Kaiapoi. She remembered that taua Ruru birthed her and her siblings at home. Taua Ruru was Tom Paiki's grandmother. Neta remembered another Māori midwife in the Riverton area, Piki Manning (Dacker, 1980). Neta Hopkinson (nee Barrett) and Tiratahi on her mother's side were the granddaughters of Henare Kokoro and Mere Whitau.

Meri Crofts spoke of her taua (grandmother), Meri Matehaere Ruru-Werata from Koukourarata (Port Levy), and her grandfather, Poihipi Werata from Tūāhiwi, birthing five of their eight babies in their whare, which was a tent, situated at Tūāhiwi in the 1920s. The remaining children were born at Koukourarata (Port Levy). Meri's taua and poua raised her, and she remembered the other taua at Tūāhiwi and Koukourarata; they were known to birth all the local babies. Meri recalls their names were Lillian Taratoa, Reria Wallace, Waireti Hokianga-Ruru and Tipuoraka Ruru. Meri believed these wāhine were experienced in midwifery knowledge and attended many whānau throughout the 1930s in the district and surrounding areas.

Meri was encouraged to return to Koukourarata when she became pregnant with her first child to be with and cared for by her whānau. She did so for a brief period before missing her husband Charlie and making the decision to return to Wellington, where they were based at this time, to be with him. Meri said she remembers her grandmother and other aunties at the time were not happy with her decision to return to her husband and to travel while pregnant. She also remembers that they did not understand her desire to work through her pregnancy. Meri knew this was very different to how her taua perceived she should act, and she remembers the tension this created between her and her taua (M. Crofts, Ngāi Tahu, kaumātua).

Amiria Stirling was not a midwife but had some nursing training when she was a young girl during the typhoid epidemic along the coast between Gisborne and the Bay of Plenty. Later, Amiria worked as a nurse around the Bay of Plenty, and many local Māori would choose Amiria over the local district nurse; often turning up to her house to seek her assistance or requesting her to attend births because they trusted her and because she was closer than any other medical help. Lilian Stirling and her sister, Kiwa Hutchings, were affiliated to Ngāi Tahu through their grandfather, Duncan Stirling, and his connections to Tūāhuriri through Tahu Potiki and Porourangi (Stirling, Personal Communication, 2018; Salmond, 1976, p. 92).

Amiria Stirling's two daughters, Lilian Stirling (aged ten now 84 years old) and Kiwa Hutchings (11 years now aged 85 years), remember their mother taking off on horseback to various homes situated a few miles from their own to attend labouring women. She would be away for weeks and, on the odd occasion, she would return home with a sick newborn, determined to do what the local doctor was not prepared to do and

that was to give these babies another chance. Amiria had a technique that involved placing the pēpi in a sling in close contact with the body where she kept them close. Lilian said Amiria rescued a few babies during her midwifery years using this technique (Stirling, Personal Communication, 2018). Although Amiria lived in the North Island, her role as a midwife has been fostered by her now elderly children as a role of great mana because of her maternity skills and great lengths she would take to support whānau around birth.

Lay midwives, both male and female, in Ngāi Tahu carried a great responsibility and were vitally needed in all Māori kaik (villages) to nurse the ill, welcome life and often to prepare dead bodies for tangi. They were at the forefront of tikanga and kawa, either conducting rituals themselves, such as whenua burial or assisting appointed kaumātua to carry out customary practices around birth (Beattie, 1994; M. Crofts, Ngāi Tahu, kaumātua; Hutchings, Ngāti Porou, Te Whānau ā Āpanui, kaumātua; Tikao, 2013).

Kupu Whakarāpopoto (Summary)

Tikanga (traditions) contribute to the identity of culture and provide a platform to transmit cultural knowledge about beliefs and values from one generation to the next. Ngāi Tahu tribal historian Te Maire Tau (2003) supports the late American Professor and writer Joseph Campbell (1972) when he states that rituals are enactments of myths and the necessity of ritual in the lives of Māori was and remains a vital component of being physically and spiritually well.

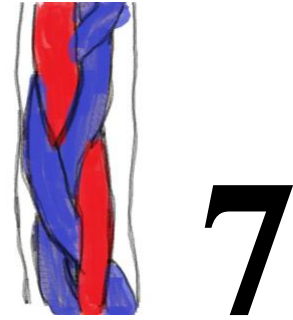
This chapter explored the following knowledge platforms:

- rituals performed with karakia, tūā, tohi and pure, creation korero;
- waiata and, specifically, oriori;
- traditional birthing practices; and
- Māori midwives who practiced customary birthing practices with whānau Māori.

What we can surmise from exploring rituals, waiata, toi Māori, tikanga hapūtanga and kaiwhakawhānau (those who assisted with the births), is that every component of customary birthing practices discussed in this chapter was essential in the confirmation of identity. These unique practices and rituals prepare a tūrangawaewae (place to stand) for the newborn, parents, whānau and hapū. What was put in place to ensure optimum health for the pēpi benefited all who were involved. Hirini Mead (2003) remarked that whānau are deciding for themselves what aspects of customary birthing tikanga they want to revive and are able to manage within their birthing plans. Whānau are thus making efforts to seek the mātauranga that supports the tikanga and, like their tūpuna, accumulate experience by implementing the tikanga (p. 302).

In addition, the frequent reinforcement of creation pūrākau, symbols, designs, mythological characters and messages via oratory (such as karakia, waiata, pūrākau) and visual formats (as in toi Māori (Māori artforms) repetitively tell Māori who they were and why they did things certain ways. Other Indigenous collectives have experienced a similar pathway to Ngāi Tahu; their learning from the revitalisation of their traditional birthing practices provides guidance for Ngāi Tahu as to what can be achieved with perseverance and government support.

The next chapter looks at the Mexican Indian, First Nations and Inuit peoples, and what we can learned from removing ourselves from our cultural conundrum, in order to learn from others and collectively work towards the rebirthing of our traditional maternity practices for Indigenous growth and cultural wellbeing.



Pēpitanga / Indigenous Comparative Review

Kei tawhiti te kai; kai te waro te kai te kainga

Ko te Tīmatatanga (Introduction)

Knowledge can sometimes be better understood from a position of distance than one of immediacy. In an attempt to appreciate the intricacies of Ngāi Tahu's creation mythology and birthing tikanga (customs), I have found it beneficial to step away from my culture and re-enter the narrative through the cultural lenses of two other Indigenous collectives. Comparing lenses or taking different perspectives of an object, in this instance a culture, challenges the viewer to rethink their understanding of a culture critically. Much more information can be added when a culture is re-examined with a renewed viewpoint (Walk, 1998).

As mentioned in the main introduction to this doctoral thesis, under a kaupapa Māori practice and approach to research and utilising the pōwhiri (formal welcome) process. The manuhiri (visitors), in this case, the First Nations and Inuit people are invited to the paepae (speaker's bench) once the haukainga (home people) have spoken. The 'rākau' (speaking stick) is metaphorically handed from the haukainga to the manuhiri

as an invitation to speak. Once the manuhuri have conversed, the rākau is handed back to the haukainga to conclude the pōwhiri formalities. Placing this chapter towards the end of this doctoral thesis allows for a holistic and evolving narrative to be discovered and unfolded. To block out discussions in a more traditional academic thesis approach by returning this chapter to the literature review or scattering it amongst the thesis restrains the holistic flow that is often associated with Indigenous research (Henry and Pene, 2001; Smith, 2003; Smith, 1999b, 2000).

An Indigenous comparative review compares other cultural traits or connections between cultures and across societies. For this doctoral research, the term Indigenous is used to describe ethnic groups who are affiliated with the earliest inhabitants of a specific region. These people may live a nomadic lifestyle but are still associated with a defined territory or reside on the land their original forebears dwelled. The United Nations (UN) working group on Indigenous populations define Indigenous people as a collective with occupation and use of specific land area, and enduring expression of cultural uniqueness. Those who self-identify and are recognised by other groups, such as state authorities as belonging to that Indigenous collective. Indigenous people have, according to the United Nations, retained their “social, cultural, economic and political characteristics that are distinct from those of the dominant societies in which they live” (2019, np). The fourth definition for Indigenous is someone who has had an experience of subjugation, marginalisation, dispossession, exclusion or discrimination (Bell, 2001; Turner, 2003).

It is noted that Indigenous collectives have at least five features in common and these are: learned, shared, patterned (integrated), adaptive, and symbolic. Indigenous comparative review assesses the relationship between traits and cultures across societies (Walk, 1998). The purpose of this Indigenous comparative review was to discover whether what we have experienced here in Aotearoa, with the decline of customary Ngāi Tahu birthing practices, is exclusive to Ngāi Tahu whānui or a phenomenon shared by other Indigenous cultures.

This Indigenous comparative review is also intended to remove a sense of cultural isolation when analysing a unique culture. To be able to take from the findings a collective step forward in terms of what can be learned from others to pursue the revitalisation of customary birthing knowledge and practices in our current context.

Te Rūnanga o Ngāi Tahu has formed a close cultural alliance with Canadian First Nations through the Ngāi Tahu Research Centre (NTRC) at the University of Canterbury. NTRC was established in 2011 to grow Ngāi Tahu's intellectual leadership, they signed a Memorandum of Understanding with the Tulo Centre of Indigenous Economics in Kamloops BC, Canada. They have contributed to the development of courses in applied economics which will a joint course between the two centres. The MOU has led to annual reciprocal visits between NTRC and the First Nations reserves that provides an exchange of cultural insights on tribal initiatives.

This chapter, therefore, reviews the revitalisation of customary birthing practices for the First Nations and Inuit people. The selection of these tribal clans has arisen from a literature review on the programmes of and by First Nations and Inuit midwives, such as Rachel Dennis and Carol Couchie of K'Tigaaning Midwives in Nipissing First Nations, The Sixth Nation Birth in Ontario, the Seventh Generation midwifery collective and the work of author, scientist and advocate for Indigenous birthing rights Dr Celia Benoit. Their stories and visions for the reclamation of customary birthing knowledge for their peoples are analogous to those of Ngāi Tahu. It was these particular Indigenous stories, from the writers mentioned, about the decolonisation of birth that led to this cross-cultural inquiry on this subject.

The first section of this chapter provides an overview of population statistics and demographics that highlight a growing Indigenous population with more births and the elderly living longer. The increasing Indigenous birth rate is a strong indicator of the need for Indigenous birthing practices and support in all Indigenous communities in Canada. A review of key Canadian statutes as a historical context follows; it explores how the First Nations and later the Inuit peoples have struggled to have their traditions and values acknowledged in Canada, including their Indigenous birthing practices. These statutes have severely impacted the health and wealth of the First Nations and Inuit communities and have contributed to the loss of their customary birthing practices. Outlining the key laws is a poignant reminder of how disempowering legislation can be over Indigenous peoples. Also in this section, critical creation narratives that formed the basis of many customary birthing practices and rituals are discussed. These practices would still be utilised today if the hospitalisation of birth, a process encouraged by Western laws and policies, had not taken hold.

In the latter part of section one, a contemporary overview of First Nations and Inuit populations ascertains where these Indigenous collectives are predominantly located. The chapter then highlights customary birthing practices and traditions before discussing the current Indigenous maternity care provision and midwifery training facilities in Canada. Particular attention is given to how effective these services have been and remain today, particularly in terms of the struggles and rewards of meeting the maternity needs of their Indigenous communities.

This chapter concludes with a reflection on what is understood to be the respective positions of the First Nations and Inuit peoples on the renaissance of their customary birthing traditions. This section also discusses how the key findings may encourage Ngāi Tahu to consider establish a stand-alone primary birthing unit run under a kaupapa Māori philosophy.

7.1 Section One: First Nations and Inuit peoples of Canada

According to the 2016 government census, 1,673,785 Indigenous people live in Canada, almost five percent of the total Canadian population. The Indigenous population has grown by 42.5 percent since the 2006 census, which accounts for a growth rate of four times that of the non-Indigenous population. The population growth is attributed to high fertility rates and longer life expectancy alongside more people identifying with their Indigenous ancestry; this will be discussed in more detail in the following section (Kukutai & Rarere, 2014).

Overall, Statistics Canada (2017) highlighted that First Nations are the most prominent of the Canadian Indigenous population, with nearly three percent of the total population, and 600 First Nations bands live on reserves and in urban areas. The First Nations people identify with names of their particular nation, for instance, the Mohawk nation, the Cree or Oneida nation. First Nations communities consist of a conglomerate of six groups: Woodland, Iroquoian, Plains, Plateau, Pacific Coast and the Mackenzie and Yukon River Basin. They live south of the Arctic Circle in the western provinces, with over half living in British Columbia, Alberta, Manitoba and Saskatchewan. One-quarter of First Nations live in Ontario and approximately nine percent live in Quebec (Statistics Canada, 2017).



Fig.14 Provinces and territories of Canada (<http://en.wikipedia.org/wiki/Provinces> and territories of Canada. Map of Canada)

The other prominent Indigenous collective in Canada is the Inuit peoples, who make up 65,025 of the total Indigenous population (Statistics Canada Census, 2016). Inuit, meaning “people”, or Inuk, meaning the person, are considered a distinct Indigenous people of the westernmost Arctic to the eastern coast of Newfoundland and Labrador. The Inuit term their homelands as Inuit Nunangat, encompassing land, water and ice. In the 2016 census, the majority of Inuit lived in Nunavut, with the rest residing in Nunavik (Statistics Canada, 2017).

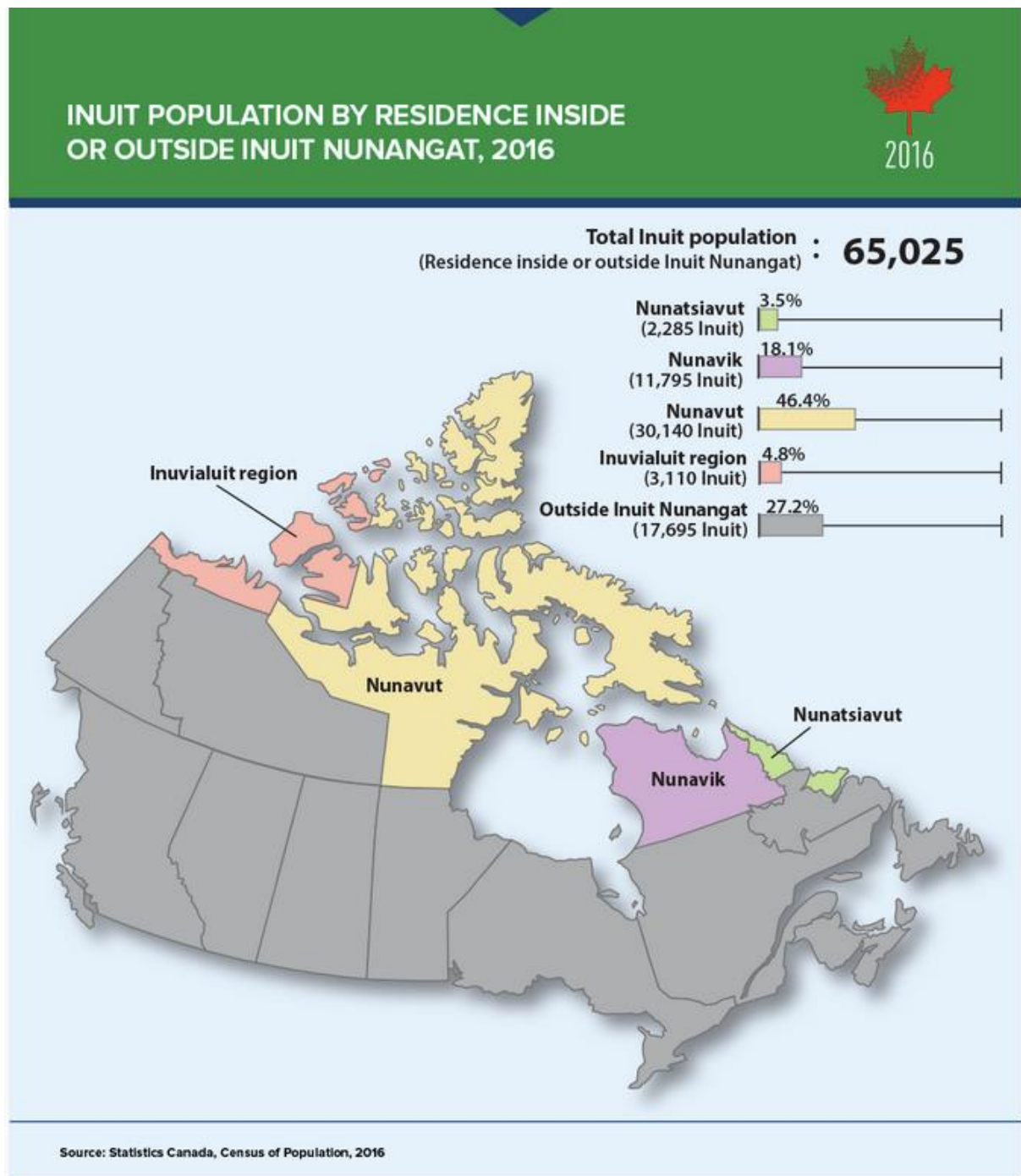


Fig.15 Census of Population retrieved from Statistics Canada, 2016. www.statcan.gc.ca/census

Inuit are seasonal hunters and gatherers who also travel large distances to trade copper, iron, soapstone and animal furs with other Inuit all over the central Arctic. Traditionally, the Inuit people identified with a band name that was determined by their location and what they hunted or gathered. When the Indian Act in 1876 came into fruition, the Act redefined the term “band” as a “body of Indians”, and these bands became the local administration body for Indian and Northern Affairs Canada (INAC)

under the federal government. Most bands have reserve lands with band offices located on these reserves. However, bands do not own the land they live on, the title of which is held instead by the federal government. This is justified by the federal government acquiring the lands more than one hundred years ago (Dwyer & Burgan, 2012; Milroy, 1978; Sidney, 1998). Cole Harris (2002) articulated the reality of the situation for the First Nations when he argued that Indian Reserve Commissioners struggled with the large and difficult terrain of First Nations lands, so that by the time they arrived to set the reserve boundaries, they did so in great haste with minimal consideration given to the Indigenous people who the reserves were set out for. These reserves ended up being diminutive to the needs of the locals while the rest of the provinces were allocated to the crown and third-party interests for development and commercial gain. Harris (2002) contended that this act of calculating the land reserves for the Indigenous people of Canada put the Indian Reserve Commissioners most powerfully in a space and place while the First Nations members became controlled by others. In Harris's (2002) introduction to his book, *Making Native Space*, he stated that placing Indigenous people on reserves was about "the displacement of people from their land and it's repossession by others" (p. xxiv).

The third Indigenous nation of Canada is the Métis, whose population arose with the arrival of the European fur traders into west central North America in the eighteenth century. The fur traders married into the Indigenous community and eventually constructed their own Métis identity. Today, the Métis population has the most substantial growth of the Indigenous communities, growing 51.2 percent in just ten years since the 2006 census. The Métis make up 32.3 percent of the total Indigenous population and 1.4 percent of the total population. For this Indigenous comparative review, I have concentrated on the First Nations and Inuit communities. They are substantial populations in themselves. I also appreciate the many nation bands within each, but for the purposes of this review, I refer to their collective identities "First Nations" and "Inuit" peoples. This next section briefly addresses the growth of the Indigenous population and reasons for this rapid rise.

The rise of the Indigenous population in Canada

Observing population trends can aid the instigation of appropriate maternity care in advance, to better meet the need of populations with the greatest growth. In this instance, the latest census data is indicating a higher Indigenous birth rate with a younger demographic of mothers and fathers. The Inuit population (65,000) has been on the rise since 2006, with an increase of 29.1 percent in 2016. This figure coincides with the overall Indigenous population growth in Canada of 42 percent since 2006 to 2016, which is four times faster than the total Canadian population. The most growth can be seen in urban and reserve-based Indigenous communities. First Nations and Inuit children are more likely to be living in a range of family settings with both parents and grandparents (Statistic Canada, 2016).

Up until 1996, Statistics Canada would use the answers from the land and language questions in the census to gather ethnicity data. No one could self-identify in the census prior to 1996. From 1996, the census included a question about visible minorities, which did allow for ethnic self-identification. In the 2016 census, the ethnicity questions were redefined and were approached in four ways: ancestry, Indigenous group, registered or Treaty Indian status and Indian band membership. The wording of the questions was adjusted to reflect the latest terminology in order to gain better accuracy, and perhaps greater uptake of census completion (Boyd et al., 2000; Statistics Canada, 2016).

According to Robson and Reid's (2001) *Ethnicity Matters* review for Statistics New Zealand, the quality of data can be impeded by a number of variables; validity being one of them. How people interpret ethnicity questions in census surveys will be influenced by people's ability to engage with the question, the purpose of how the information will be used, and who is seeking the information. If people do not agree with the question or how it is being asked or why it is being asked this may affect the way they answer these questions, which will affect the overall results of the survey or census. Also, the responses to the ethnicity questions for people of diverse ancestry can be swayed by their parental loyalty to both or one parent. This parental obligation also impacts on how they describe their own identity. Therefore, the improved quality and

quantity of questions in the latest Canadian census could also be a strong contributor to the growth of the Indigenous population (Robson and Reid, 2001; Thompson, 2010).

The 2017 government pledged to amend the Indian Act of 1876 to remove sexual discrimination and restore status to First Nations women and their children born before 1985. This effectively ended another barrier to Indigenous growth and development. Women who have married non-status partners can now pass down their maternal status, with no restrictions, to their children. This is likely to show another increase in Indigenous population figures in the next census collection (William, 2018). Another issue regarding census accuracy, is whether the Indigenous voice on national demographics has been consulted and included in the census question design. Active consultation with the Indigenous communities has not been investigated in this thesis but the sources from which the 2016 census and Statistics Canada draw upon appear to be appropriate. These sources include the following: National Household Surveys, Aboriginal Peoples Survey, the Canadian Community Health Survey, the Labour Force Survey and the General Social Survey, all of which, contribute to the gathering of the Indigenous demographics (Statistics Canada, 2016).

Statistics Canada has drawn attention to continual growth in the Indigenous populations of Canada in both urban and reserve-based communities. The 2016 census also highlighted that family units are remaining together. The layers of generations under the same roof could also indicate a greater chance of cultural knowledge retention and intergenerational knowledge transmission. Retaining cultural knowledge has been a difficult task for the Indigenous people of Canada given the number of legal obstacles that have been forced upon them from the 19th century. This next section addresses a few of these statutes to gain insight into the First Nations and Inuit people's reality and why it is crucial they reclaim their cultural status.

Statutes and effects on First Nations and Inuit peoples' identity and self-government

Even after my initial scope of the literature pertaining to First Nations and Inuit people, I realised how powerful government legislation has been on changing the life course

and cultural practices of Indigenous communities since the 1830s. In this section, I therefore explain key statutes that have had significant impacts on shaping the cultural, economic and other outcomes for First Nations and Inuit peoples. The statutes reviewed had the individual and cumulative effect of essentially limiting the rights of Indigenous peoples in Canada especially in relation to land tenure and government. The key statutes discussed are the Crown Land Protection Act 1839, the Gradual Civilization Act 1857, the Canadian Constitution Act 1867, the Gradual Enfranchisement Act 1869 and the Indian Act 1876. I briefly discuss the main purposes of the first three statutes and then concentrate on the Indian Act 1876 because of its wide-ranging ramifications for Indigenous peoples.

In 1839 the Crown Land Protection Act enabled the government to be the guardian of all Crown lands, which included the Aboriginal reserves. This Act was the first to categorize reserves as Crown lands that were to be protected by the government. Government protection over the reserves came in the form of limiting the rights of settlers using the First Nations reserves (Government of Canada, 2017).

The Gradual Civilization Act 1857 offered 50 acres of land to First Nations individuals if they became a civilised citizen and renounced their traditional lifestyles. The government encouraged First Nations people to voluntarily relinquish their cultural identity and tribal connections in return for land and the right to vote. First Nations did not engage with what this Act was enticing them to do, which forced the government to automatically impose this Act upon all First Nations people in order to civilise the nations (Bartlett, 1980, Government of Canada, 2017).

First Nations people lost their right to self-governance in 1867 with the passing of the Constitution Act that gave the government jurisdiction over “Indians and Lands reserved for the Indians”. Thereby removing any existing ability for First Nations peoples to manage their affairs whilst being heavily governed by rules imposed by the government of Canada (Bartlett, 1980; Milroy, 1978; Woodward, 1994). The Constitution Act 1867 is further discussed below.

The Gradual Enfranchisement Act in 1869 gave the government the power to remove the unique distinctions or rights of a First Nations person and force First Nations to assimilate to the larger non-Indigenous settler population. The Gradual Civilization and Enfranchisement Acts worked on the notion of divide and conquer. The Act divided

the people then provided for the people under the guise of protection, and then blended them into the majority in order to gain greater control over all (Bartlett, 1980; Daniel, 2013; Milroy, 1978; Woodward, 1994).

Many years later and after many attempts by various First Nations collectives to have their land claims heard, their plight was further impeded. The federal government in 1927 passed a statute that prohibited First Nations from undertaking any form of fundraising to assist them taking land claims to the government without the government's permission (Government of Canada, 2017). In 1933, amendments to the Gradual Enfranchisement Act 1869 gave further power to the government to force enfranchisement that legally allowed the government to terminate a person's Indian status and give them full Canadian citizenship at the cost of relinquishing their ancestral identity (Crey, 2009).

The Indian Act 1876

The Indian Act 1876 is a strong example of the struggles that both First Nations and Inuit peoples have had to endure through the discriminating rules set out in the Act. It advocated for both First Nations and Inuit peoples to surrender their cultural identity in order to gain Canadian citizenship. Both First Nations and the Inuit peoples have suffered from the ongoing negative repercussions of this Act in the many facets of their lives, including their right to access and implement customary birthing practices (Bartlett, 1980).

The Indian Act provided another layer of government control over the Indigenous communities by replacing their traditional governance structures. The government constructed band councils that became accountable to the federal Department of Indian Affairs. Under the Indian Act, terms were applied to the First Nations to describe the way the government categorised them or legally recognised their First Nations lineage. Therefore, "status Indians" were individuals registered as an Indian under the Indian Act, who are then said to be eligible for benefits offered by the federal, provincial or territorial governments, including the right to live on reserve land (Harris, 2002; Henderson, 2018). Under the Indian Act, the Indian status can be removed or deleted from the register by the government registrar at any time. This could be done in the

following instances: if the person was a woman with Indian status who married a non-status man; through enfranchisement, if they were an Indian with status, they could apply to relinquish their status in order to gain voting rights; or if they lived away from Canada for longer than five years, they would be deleted from the Indian status register. In 1985, the government passed an act to alter the Indian Act (the amendment was known as Bill C-31) that effectively enabled people to restore their Indian status if it had been removed prior to 1985 (Asch, 1984; Borrows, 2002).

Further amendments to the Indian Act over the years struck at the heart of First Nations identities, livelihoods and wellbeing. For instance, governments forced First Nations children to attend industrial or residential schools between 1894 and 1920, and amendments stopped traditional ceremonies, such as the potlatch ceremony in 1884 (Woodward, 1994). The potlatch ceremony encompassed a range of gift-giving ceremonies that celebrated marriage, birth, naming of children, death, when a young person came of age, and many other significant events relevant to the Indigenous communities of Canada. Guests would receive gifts, witness speeches, and take part in dancing and celebratory feasts over many days. The potlatch ceremony remains a central display of Indigenous identity, where the past links to the future and the spirit to the physical world. The potlatch ceremony was originally stopped for the First Nations on the West Coast but over time the ban spread across Canada (Monkman, 2017). Colonial officials could not fathom the giving away of possessions and aligned this practice to people deemed unstable in mind (Kan, 2016). It was also seen as a non-Christian display that opposed colonisation and threatened to disrupt full assimilation through the retention of their cultural practices (Daniel, 2013; Milroy, 1978; Woodard, 1994; Scow, 1996). The Indian Act was amended in 1880, when it became a criminal offence if an Indian person engaged in or assisted with potlatch celebrations (Scow, 1996). They were banned by the government from 1885 until 1951 in a powerful bid to dominate over Indigenous traditions. The potlatch ban was lifted in 1951, when a change to Section 149 of the Indian Act was erased during a revision of the Act (Daniel, 2013; Milroy, 1978; Woodard, 1994; Scow, 1996).

The Royal Commission on Aboriginal Peoples in 1996 found that the Indian Act was oppressive to the Indian people and their culture. The Royal Commission report described the Act as a source of assimilation resulting in cultural devastation (Dussault & Erasmus, 1996). Many amendments further defined the Indian Act, but the core

remains close to the original 1876 version. Regardless of the version and amendments, the impact of the Indian Act on the First Nations people was powerful. Their lives and identity were, and still are, firmly bound by the restraints placed upon them by the federal government (Dussault & Erasmus, 1996; Milroy, 1978). For example, political historians described the Indian Act as invasive and paternalistic due to the impositions by the federal government on aboriginal management structures, such as band councils. The Indian Act also enabled the government to determine the location of the First Nations people's reserves and who and how individuals qualified as a First Nations person (Milloy, 2008; Miller, 1991; Royal Commission on Aboriginal Peoples, 1996).

The Inuit peoples were not subject to the 1876 Indian Act until 1939. The Canadian federal government decided to amend the application of the Indian Act, which then placed the Inuit peoples under the responsibility of the federal government as well. The government began to use their judicial powers to force the Inuit peoples to stop their nomadic lifestyle and adopt a sedentary community life (Miller, 1991; Royal Commission on Aboriginal Peoples, 1996). In addition to this, the federal government in 1945 dispensed disc numbers to each Inuit person to wear either sewn into their clothing, printed on a metal disc or hung around their necks. This was an identity system known as E-numbers that assisted federal administrators to have accurate records of the Inuit surnames in order to identify Inuit people for trading, census information and who was eligible for family allowances. The numbers featured an alphanumeric code, such as E9-4978, which referred to where the Inuit individual was geographically located along with their unique four-digit number. These disc numbers disrespectfully renamed Inuit people simply for the ease of federal government administration and disregarded that Inuit people already had their names given to them at birth. The allocations of these discs continued until 1972. In Quebec, during the 1980s, the discs were made defunct in favour of using surnames instead for Inuit identification (MacDonald-Dupuis, 2015; Royal Commission on Aboriginal Peoples, 1996).

Today, the Canadian federal government is still empowered to address the affairs of registered Indians and those living on reserves under the Indian Act (1985). The government developed Band Councils and other governing structures within the Indian communities that negatively impacted their customary rites and traditions. The Indian Act gave the federal government the right to define Indian status and have control over

their Indian reserves concerning size and as mentioned, location (Ontario, 1990; Royal Commission on Aboriginal Peoples, 1996).

Organisations such as the United Nations Commission on Human Rights, Amnesty International and the Canadian Human Rights Commission have all agreed with First Nations and Inuit peoples regarding the diminishment of their rights due to the federal government's poor treatment (Royal Commission on Aboriginal Peoples, 1996). However, there have been mixed responses to the status of the Indian Act by some First Nations and Inuit groups. Some Indigenous factions are eager to be rid of the Indian Act while others are uncertain if this would lead to righting the wrongs. The Indian Act connected Indigenous cohorts legally and historically to Canada and, until something else of the same value is in place, they run the risk of further oppression and struggle without it (Beazley, 2017; Hansen, 2009).

Concerns about the Indian Act are not new and arose after the Second World War. At that time, the Canadian government took a new approach to their governance issues over First Nations, Inuit and Métis peoples by reviewing the Indian Act and specifically addressing areas that were restrictive and oppressive to the native nations. This review eventually resulted in the government establishing a joint committee in 1951 to consult for the first time with First Nations and Inuit communities about changes to the Indian Act. The Indian Act was redressed, and extreme restrictions were removed. For instance, the potlatch ceremony became legalised, greater access to public venues was granted to First Nations that were previously barred, ceremonial dress was allowed to be worn off the reserve without having to seek prior permission from government Indian agents, and First Nations women were permitted to vote in band councils.¹ However, the discrimination inflicted by the Indian Act over the years was demoralising in its bid to assimilate Indigenous people into mainstream society (Bartlett, 1980; Woodward, 1994).

Canadian Prime Minister Pierre Trudeau proposed a policy known as the White Paper in 1969. The purpose of this policy was to abolish the 1876 Indian Act and disestablish the Department of Indian Affairs in a bid for First Nations to become Canadian citizens.

¹ For further reading on the consultation process and community views, see the Native Women's Association of Canada "*Implementing Bill C-31*" - A summary of issues. 1988. D. Beazley, "*Decolonising the Indian Act. No one likes it so why is it so hard to change*", 2017.

However, this was rejected by a large number of First Nations, as they wanted their Indigenous uniqueness to be acknowledged and not assimilated into a Canadian identity. The federal government dropped the White Paper and Milroy (2008) credited this response to the Indigenous collectives who opposed it. He described this as a defining moment that contributed towards the federal government reconsidering their First Nations assimilation policies and instead working towards protecting the rights of First Nations.

Another amendment to the Indian Act occurred in 2017, which provided new prerogatives under the Indian Register. Those who could now gain entitlement would also have the right to be added to the Band List under the Indian Affairs. This amendment focused on reducing sexual discrimination by restoring the status of women, and their children born before 1985. The amendment gave women the right to pass their status down to their children (Bartlett, 1980; Statutes of Canada, 2017; Woodard, 1994). These changes have significant ramifications concerning cultural heritage and knowledge continuation, not least concerning the relearning and retention of customary birthing rituals and practices, such as those mentioned below under the heading First Nations and Inuit Birthing Rituals and Practices.

Canadian Constitution Act 1982

The Canadian Constitution Act in 1982 evoked the Canadian Charter of Rights and Freedoms within the Act. This charter protects the legal and human rights of Canadian people from government policies. Section 35 of the Constitution Act specifically acknowledges and asserts the Indigenous rights that protect cultural practices that are patently linked to their cultural identity. Section 35 also protects Indigenous land titles that safeguard the land for traditional practices. However, for some First Nations, the Constitution Act was also problematic because it was another statute that did not recognise the more complex tapestry of the many customary forms of identity. Instead, the Act preferenced the three broad aboriginal groups in Canada: First Nations, Inuit and the Métis people. Therefore, the Constitution Act can potentially be perceived as a step in the right direction in terms of Indigenous equality, but it did little to empower

Indigenous cultures to take part in policy and legislation of direct concern to them (Asch, 1984; Bornous, 2002; Government of Canada, 2017).

Discussion

As discussed, the laws examined have had the effect of empowering the government to remove the rights of Indigenous people to be themselves and have any form of autonomy. Through government legislation, Indigenous people were forced to assimilate and were disempowered legally to fight back. The numerous amendments to the Indian Act created further compulsory actions, such as forcing First Nations children to attend industrial and residential schools between 1894 and 1920. In addition, making customary celebrations such as the potlatch ceremony illegal to perform. It seemed to be perceived by government representatives that the retention of customary practices disrupted full assimilation; therefore, shutting these practices down would eventually turn First Nations people into Canadian citizens. The Indian Act was not enforced upon the Inuit people until 1939 but has had equally demoralising effects, particularly regarding the federal government dispensing disc numbers to aid the formal identification of Inuit peoples. These disc numbers often replaced the acknowledgement of birth names. Disc allocation did not stop until the late 1970s.

Despite the Indian Act having significant impact on the lives and cultural norms of First Nations and Inuit peoples, some believe that the abolishment of the Act cannot occur until something better is in place. In 1982, the Canadian Constitution Act evoked the Canadian Charter of Rights and Freedoms within the Indian Act. This protects the legal and human rights of Canadian people from government policies. This is a vitally important section to safeguard Indigenous rights and cultural practices of First Nations and Inuit peoples from any further cultural discrimination.

The destructive influence of law on customary lore and practices has also precipitated a counter response by Indigenous people to secure the knowledge systems that they still have, in particular, birthing knowledge, traditions and practices. The cornerstone of customary knowledge is tribal creation stories. Creation mythology has played a critical part in defining Indigenous peoples' existence and lineage. It is also from creation

narratives that people continue to harness strength in order to sustain their cultural knowledge (Bruyere, 2012). The next section identifies what stories are known, learn how birthing is valued by the First Nations and Inuit peoples and gain further insight into the spiritual, historical and wider connections between humans and the world around them.

Creation Mythology

The creation mythologies associated with the First Nations frequently describe an animal coming from the depths of the Earth's waters. In one tradition, the turtle's back formed the earth and this creation came to be known as Turtle Island (Francis, Jones, & Smith, 1996). Another strand of this creation story is that of the Sky People. The Sky People were said to live in the sky as the land had not been formed (Francis, Jones, & Smith, 1996).

This First Nations creation narrative begins when the chief's daughter becomes ill. A wise elder instructed the chief to lay his daughter next to an uprooted tree. When he placed his daughter next to the tree, the tree fell back through its own hole dragging the chief's daughter with it. Two swans saw the girl falling from the sky and swam to brace her fall. They placed her gently on the back of the Giant Turtle. The animals gathered around the girl, and the Giant Turtles Council decided that this was a sign of good fortune. The Giant Turtle ordered the animals to find the tree from the sea and bring it to him. Many animals attempted to find the tree below the sea, but many died doing so. An aging female toad dived down and after a long time came back up with a mouthful of earth from the roots of the tree. Before dying, she spat this earth onto the back of the Giant Turtle, and he began to grow into an island large enough for the Sky Women to live on. Darkness enclosed the island, and the Great Turtle Council concluded that they needed to create light. The Council gathered lightning and formed two lightning balls, called the sun and the moon (Francis, Jones, & Smith, 1996). Turtle Island honoured the sturdiness and commitment the turtle made for the growth of others. The turtle is pivotal in the origin of the earth for First Nations and Inuit people (Garfield, 1986). Another similar version of this creation story from the Iroquis nation consisting of several nations of Indigenous people in North America. Their story suggests that the

Sky women birthed twins, one called Tharonhiawagon, who was kind, and another, Tawiskaron who was known as the evil twin; and from her breasts, she nurtured three sisters: corn, beans, and squash (Axtells, 1981; Siquin, 2009).

Inuit traditions spoke of their ancestral ability to maneuver between the physical and spiritual realm and transform into animals and vice versa. Their traditions highlighted the supernatural powers of individuals and their ability to create change, seek assistance and find enlightenment (Boas, 2006; Stevens, 1971). Creation narratives would often refer to the “transformers” or Great Spirit amongst the many Indigenous nations. Stories told of the transformer diving or instructing animals to plunge into the sacred waters to retrieve mud from which they would shape the earth (Boas, 2006; Stevens, 1971).

One story spoke of Gloosap creating the moon, sun, fish, animals and humans and the other transformer, known as Malsum, forming the landscape and snakes. Malsum created anything that made life difficult for humans (Davies, 2002; Friesen, 2000). The moon is an essential symbol, a vessel of knowledge for the First Nations and Inuit people. The moon is often referenced with the women’s monthly menstruation cycle; “the moon is considered a gift, a time of natural cleansing” (Bruyere, 2012, p. 41). Other life cycles can be contained within the medicine wheel depicted in First Nations and Inuit creation narratives. The medicine wheel represents the circle of life and all the connections between species. Therefore, the circle is perceived as a shape that denotes the renewal and regeneration of all things created (Ontario Secondary School Teachers’ Federation, 2008).

The creation mythology and symbolism, such as the circle of life, all express connections, relationships and a flow of movement that then led to the next development. Often there is a coming together of an animal and another demi-god or deities that appear human, these narratives often have a descent from the sky or an upper realm or an ascent from below the sea. There is also a higher authority backed by a number of advisors that provide expertise and there seems to be a martyr or a sacrificial component that dies in order to bring change or the answer to move to the next stage of creation, for instance the turtle spitting a piece of earth from the Sky women’s tree in order for the landscape to form (Boas, 2006; Campbell, 1960, 2004; Clark, 1987; Robinson, 2018).

Creation narratives carry a duality that creates balance, for instance: evil and good twins and dark and light space. There seems to be a common desire to transition from one more oppressing heavier space to one with more light and expansion. Another theme is the ability of the characters to transform between animal and humans, between what could be perceived as the spiritual realm and the physical. There is a continuous drive in creation mythology for a balanced platform that then offers space for further growth. First Nations customary birthing practices perpetuate a penchant for equilibrium between mother and child, child and their ancestral connections, and child and their natural world. In a sense, both creation mythology and customary birthing practices lay down a spiritual foundation in preparation for new life and a continuation of a renewal process. The next section provides more detail on how customary birthing rituals and practices associated with the First Nations and Inuit peoples are a fusion of the physical world and spiritual realm to best prepare the pregnant woman and the family for the arrival of a child.

First Nations and Inuit Birthing Rituals and Practices

First Nations and Inuit birthing traditions validate cultural identity, and are reminiscent of how vitally important the land was to the wellbeing of Indigenous peoples. A First Nations midwife, Racheal Dennis from the K'Tigaaning Midwives in Ontario, stressed that the utilisation of traditional birthing practices brings cultural comfort to First Nations families and heals the community from past legal injustices. Dennis further describes the reclamation of birthing traditions as a restoration of balance (Balkissoon, 2018). Gilbert Fredette (2017), a counsellor in Northern Manitoba in the Norway House Cree Nation, concurs that First Nations once honoured life and death rituals but now these rituals are only occasionally acknowledged. He states that the joy of birth is celebrated less than the honouring of someone passing. Kanahus Manuel of the Neskonalith Indian Band of Secwepemic Nation in British Columbia stresses that birth in itself is an act of decolonisation and resistance (Schiedel, 2017). The return of customary birthing rituals into First Nations communities contributes to reducing the physical and spiritual damage of health inequalities suffered by the Indigenous people

of Canada, and is a proactive movement towards healing some of the historical trauma still felt by these communities (Allan & Smylie, 2015; Duong, 2018).

First Nations people believe that childbirth is a significant event that was once surrounded by sacred ceremonies welcoming the child into this world. The ceremonies also protect the mother and child in order for them to survive and to grow strong. Birthing ceremonies also assist the mother, baby and family to celebrate the arrival of a new life into the community.

In acknowledgment of the First Nations' relationship with the natural gods, babies were presented to the sun as a formal welcome to the child and mother (Gonzales, 2012). Professor Jean Biggs at the Memorial University of Newfoundland highlights that Inuit customary birthing practices in a Language and Culture Programme in 2000 facilitated a few of her students in the programme to interview two Inuit elders, Naqi Ekho and Uqsuralik Ottokie from South Baffin in the Canadian territory (Nunavut) on traditional midwifery practices (Biggs, 2000). Ekho and Ottokie agreed to the interviews because they believed they had a better life than their descendants and were able to describe the traditions that had been important to their communities. They had also seen rapid change during the modernising of the Nunavut community. They believed that sharing their life experience aided others to understand why birthing knowledge had been put aside. Uqsuralik explained:

When I am telling you these stories about how life used to be... I am not saying our way of life was better than yours. In many ways, it was not as good. However, I certainly can say we were taught to lead a perfect culturally strong life... I certainly want to pass on the importance of having strong family relationships and respecting rules (Biggs, p. 1).

Mothers taught mothers and this fulfilled an essential role in the transmission of birthing knowledge, rituals and practices to navigate wellness for the mother and baby (Archibald et al., 1996; NAHO, 2008; O'Neil et al., 1990). Ekho and Ottokie descend from mothers and grandmothers who were midwives and who delivered many Inuit babies. They said that their Inuit practices and traditions are not needed as much today due to many young mothers moving away from the community to birth in more centrally located maternity hospitals (Biggs, 2000).

Biggs' (2000) summary of Ekho and Ottokie's narrative concerned the conception of a child where the primary role of the mother was to remain in a relaxed state of mind, spiritually and physically. Worry or stress was detrimental to the development of the growing fetus. All actions of the mother, and also of those around her, appeared to have a significant impact on how this particular Inuit clan perceived the growth, mental aptitude and eventual appearance of the baby. Achieving a relaxed state was not all left to genetics and Inuit played their part in nurturing the desired outcomes for their newborns.

A form of mimicking was performed while the baby was in utero or as a newborn to encourage what the family wanted for this child. For instance, if the family wanted the child to be a good hunter, then the midwife, mother or another member of the family would perform actions of hunting to the unborn child and would also talk directly to the baby in utero of their hopes and desires (NAHO, 2008; O'Neil et al., 1990).

Ekho and Ottokie described physical touch being applied to the shaping or moulding of babies to create an ideal physical characteristic such as dimples or better-shaped ears. Massage was used during pregnancy to encourage the baby to move around in the uterus and not to become fixed in a particular position (Biggs, 2000). If the mothers were active during the day, completing their tasks and keeping a certain pace about them, then this would lead to speedy labour and birth. Similar to the messages transmitted in mythical stories, certain habits, actions or non-adherence to rituals were believed to lead to a negative consequence, such as a birth complication (Biggs, 2000).

Another example of an Inuit value during pregnancy, was metaphoric, relating the lace of a boot to that of the umbilical cord. Kamiiks are a soft boot often made out of Caribou (reindeer) skin, and most have laces at the back or front to secure the foot into the boot. In some clans, during pregnancy some mothers would not tie their kamiik laces or make sure they were not too long; this also applied to those close to her. Laces or ties represent the umbilical cord. If they were left undone, they believed that the mother was sending signals to the growing baby that reduced the risk of partial or full strangulation of the baby from the umbilical cord. Not tying the bootlaces was believed to heighten the chances of having a healthy birth (Archibald, et al., 1996; NAHO, 2008).

Ekho and Ottokie explained that the birth was not complete until the midwife had touched lightly upon the genitals of the child as soon as it was born, formalising their role as *sanaji* (or the person who created or made the newborn). It was the *sanaji* that was thought to have given the baby their physical and moral qualities. Once the baby was named, then the birth was seen as complete (Biggs, 2000). When a newborn arrived in the village, it was customary that everyone of all ages would greet the child by shaking the newborn's hand. The greeting would occur at the beginning of other welcoming ceremonies, but now it is a rare practice in many Inuit communities (Archibald, et al., 1996; NAHO, 2008; O'Neil et al., 1990).

First Nations and Inuit elders believed in ritualistic prayers and their significant role in cultural traditions. Some First Nations and Inuit elders think poor maternity outcomes are due to unhealthy choices and the inadequate preparation of parents (Cohen, 1998). Biggs explained that the elders she interviewed associated evil thoughts with grave consequences on the growth and survival of a baby, negative thoughts of others, pathogenic forces, environmental toxins, physical and emotional trauma, breach of tribal taboo, or even a lack of respect for Mother Earth and the spirit world (2000, p. 42).

Ritualistic prayer also plays a significant role in Ngāi Tahu customary birthing practices. Other similarities, outlined below, further cement the connection Indigenous collectives can have to provide moral and cultural support in the stand to reclaim these customary practices and make them once again accessible to the Indigenous communities.

Birthing Locations

Birth predominantly took place in a snow house or a skin tent (Simpson, 1892; Yarrow, 1881). A pre-colonial example in Newfoundland highlighted that women birthed in specially constructed birth tents outside, and sometimes it was noted that births took place under the canopy of the forests. The Inuit from Mittimatalik (Pond Inlet) birthed their babies alone but were given guidance and instructions from outside their dwelling or tent by others (NAHO, 2008).

Chamberlain and Barclay (2000) and Kornelsen et al., (2010) concluded that the place of birth carries paramount importance and does have an impact on the birthing outcomes of First Nations and Inuit communities. Tribal spaces are connections to their lands, environments and genealogy. This attachment between community members and the environment provided strength, not only for the birthing woman and her family but also for the community when they witness regeneration.

Birthing Positions

Traditionally Inuit women appeared to give birth in an upright position on her knees, known as the Napajug position. A straight piece of a board could also be positioned along the back of the labouring woman to ensure her back remained straight. Sometimes women would lie on their side and massage the other side of their uterus on contractions. In the hospital, the preferred position was for the woman to be in a supine position (Archibald et al., 1996; Birch et al., 2009; Wilson et al., 2013). Amongst the Inuit communities, hospital births took longer, and customary birthing practices were ignored and rarely taken seriously by the medical practitioners (Archibald et al., 1996; NAHO, 2008; O'Neil et al., 1990).

Tying and Cutting of the Umbilical Cord

Inuit traditions appeared to vary on the method of cutting the umbilical cord. Some clans would tie the cord very quickly after birth with braided sinew and then cut it, and other clans would withhold from touching the cord until it had stopped pulsating. The Caribou sinew was used to tie most umbilical cords, and the placenta mostly buried among rocks (Archibald et al., 1996; Duong, 2014; Lawford, Giles, & Bourgeault, 2018).

Moss bags and Cradleboards

Many First Nations and Inuit babies were placed into prepared moss bags immediately after birth. The moist warm moss replicated the womb environment and also provided great skin protection for baby's excretions. The moss was replaced regularly, similar to a modern nappy. If the mother needed to move around with the baby in the moss bag, she would place the baby in a cradleboard, sling or basket. The cradleboard often had cloth or leather bags that would hold the baby, and a strapping system would secure the baby into the bag. The mother would sling the cradleboard with baby onto her back like a modern day baby backpack, it could also be stood up on the ground to allow the baby to be upright or placed onto a mode of travel for a long journey (O'Driscoll et al., 2011; Olsen & Couchie, 2013; Smith, 2016).

Foods Eaten During Pregnancy and Birth

A broth of salmon and whitefish was often given to First Nations and Inuit mothers post birth for nourishment and to stimulate lactation. Women increased their intake of caribou (deer), muktuk (frozen whale skin and blubber) and seal during pregnancy. They were careful not to eat old food and would reduce berries in their diet to reduce stomach upset and any possibility of food poisoning (Archibald et al., 1996; Gilmore, 1930; Simpson, 1892; Yarrow, 1881).

Post Birth Traditions

First Nations and Inuit customary birthing practices continued into the post-partum phase to protect the baby from untoward spirits and to ensure the mother takes adequate rest. Examples of this were the use of ash or black mordents to ward away the dark

spirits and keep people protected (Obermeyer, 2000). To encourage recovery post birth, the mother would remain in the house and was not allowed to wear her moccasins for at least five days (Archibald et al., 1996; NAHO, 2008).

On the 20th day, a washing ritual may be conducted alongside a ceremony that would involve a cleansing ritual of the mother, a naming ceremony for the child and a presentation of the child to the sun. After the cleansing ceremony, a great community feast would take place. Prayers chanted through ritual cleansing processes were termed smudging. Smudging involved a bundle of sage being burned to remove evil spirits and to cleanse the space and the people in preparation for their next journey (NAHO, 2008).

The teaching of birthing traditions, such as those discussed above, have always been the role of the traditional birth attendants or midwives. Their expansive wisdom and skill set sees them highly valued in their communities. With too few of them still alive today, the challenge remains for First Nations to capture their knowledge before it dies with the remaining few.

Traditional Midwives

The definition of a midwife varies among different clans; for instance, the Nuu-chah-nulth people of the west coast of Vancouver Island in British Columbia translate midwife as “she can do everything”. The Salish people (including Nuu-Chah-nulth) translate midwife as “to watch to care”, and another British Columbian clan, the Chilcotin people, define a midwife as a women’s helper (O’Driscoll et al., 2011). The Mohawk term for midwife is “she who pulls the baby out of the earth”, the Ojibwe reference is “the one who cuts the cord”, and the Cree people describe a midwife as “the one who delivers”. These translations for the varying clan names for midwife are descriptive, yet highlight an admiration for her role in their community (Archibald et al., 1996; Benoit, 2001; O’Driscoll et al., 2011).

Traditional midwives were highly respected because their work aligned with the work of the creator (Benoit, 2001). Benoit adds that women who became midwives were said to have a calling to the profession. Their role as a midwife was to not only to deliver the babies, but also to pass on ethical and moral values. However, the role of traditional midwives has drastically declined in recent times. Reasons for this vary but all strongly

allude to the impact of colonial values over First Nations and Inuit peoples, leading to the loss of the women's right to assist with birth.

Younger First Nations and Inuit women are infrequently exposed to traditional midwifery and childbirth as it used to be in the normal everyday life of First Nations and Inuit peoples. The learning of traditional midwifery took place by watching and doing, therefore, with less traditional practices happening the future of traditional midwifery is compromised (Kaufert, 1990). Further impacts have included the use of Western medicines over customary medicines, the establishment and implementation of the residential schooling system, devastating epidemics and patriarchal government legislation and policies that have changed the socio-economic and traditional ways of the Indigenous people (Archibald et al., 1996; Benoit, 2001).

An Ontario elder from Stoney Creek recollected an example that highlighted one of the significant changes that occurred in the Indigenous practices of Canadian cultures (Benoit, 2001). In her time, she could access herbs to make traditional medicines, but the use of herbal remedies has declined because modern medicines and doctors have taken over traditional healing methods and practices. A number of Indigenous communities have forgotten herb knowledge and methods of gathering and preparing them for medicinal purposes. Traditional midwives have championed the use of herbal remedies with their clients, but they have struggled to find young protégés to pass on their knowledge. The threat being that traditional midwives will retire or pass away and so too will their knowledge. However, Canada is also experiencing a renewed focus on Indigenous midwifery practices with the establishment of more First Nations midwifery birthing centres. These centres are growing their Indigenous clientele and this inevitably drives the capacity for more Indigenous midwives to then take up the practices of their aging senior practitioners, including the art of herbal medicines (Benoit, 2001; Birch et al., 2009).

Traditional midwives, or more often termed Indigenous midwives, today have been acknowledged as holders of knowledge by their communities. Conversely, when Canada restructured its health system in the early 1970s, it appeared to give the authority to the medical physicians to dictate the changes while simultaneously disempowering other practitioners, such as traditional midwives who had worked previously in their communities for many generations providing essential maternity

care and customary knowledge. The following section provides more detail on the reasons for the health system restructure which led to First Nations and Inuit peoples being evacuated from their communities to birth.

Medicalisation of Midwifery

By the 1970s, in an effort to reduce maternal mortality in the overall Canadian population, the Ministry of Health actioned firmer and compulsory rules around hospital births for all women in Canada. However, this was not an easy solution for approximately 21 percent of the Canadian population who lived in rural areas, with a large proportion of this group being Indigenous. They had minimal maternity provisioning in many rural areas at this time and an ongoing shortage of available medical practitioners, nurses and midwives to maintain healthcare facilities. This appeared to have little influence over the restructuring of the health system and the eventual centralisation of maternity services (Elias, 2014). However, instead of improving the provision of healthcare, inclusive of maternity services into rural and remote regions, effort was put into getting rural communities to healthcare situated in larger towns and cities (JObstets, 2010). Klein et al., (2002) claimed the centralisation of healthcare actually had serious implications regarding women's health and social costs for women giving birth, and for their families. Benoit et al. (2012) argued that the adoption of the medicare system (a universal healthcare programme) in Canada in 1972 dictated that only physicians who provided maternity care services received public funding. Medicare, according to Benoit et al. (2012), effectively heralded the medicalisation of maternity care. This also coincided with the decline in the usage of midwives and in some province's midwifery became illegal.

The midwifery services that were not deemed illegal but were also not regulated were not acknowledged as part of the provincial healthcare system. This equated to some midwifery services not being covered by provincial insurance, which meant that women had to pay for a midwife themselves. This again made midwifery less accessible for Indigenous women and difficult also for midwives to remain in the workforce (McCracken, 2015). Consequently, in the 1970s, most women of any culture in Canada

moved out of their home and into hospitals to have their birth attended to by a doctor or a midwife.

Hospitals promoted the idea that they could provide modern scientific approaches to birth and wellbeing and were therefore a better place to birth. Birthing in hospital was gradually accepted amongst many Indigenous communities (Cameron, 2005; Turnbull et al., 1991). It was noted by Bruyere (2012) that the “advancement of scientific methodologies has encroached on the Aboriginal woman’s cultural norms” (p. 40). The sterile hospital environment appeared to have little regard or respect for cultural traditions. McCracken (2015) highlighted that the lack of a professional midwifery organisation at this time also contributed to the “marginalisation” of midwifery and the birth becoming a “medical intervention directed by physicians” (n.p).

O’Neil and Kaufert (1990) drew attention to the medicalisation of childbirth being another and significant example of colonial disrespect and power to dominate over another culture. What is concerning, is the social and spiritual impact on culture when the dominating culture dictates what is right in their minds over another. There was a disregard to what Indigenous cultures perceived made someone well or unwell. Preservation of traditional beliefs concerning pregnancy and childbirth is about having cultural sovereignty including perceptions of wellness (Handwerker, 1990, p. 57; Olsen & Couchie, 2013). Previous studies acknowledged by Browne and Fiske (2001), Browne (2007), and Neufield (2014), emphasise the Indigenous perspective of coping with mainstream healthcare provision in Canada. They reported that there were frequent misunderstandings between themselves and the medical practitioners based in cultural differences, communication breakdowns, medical values clashing with cultural values and negative stereotypes of Indigenous people held by the medical profession that limited the rapport and contributed to a negative relationship with the healthcare providers (Allan & Smylie, 2015).

Bruyere (2012) explains that often the Western medical model isolates the traditional experience from the individual. She further explained this by pointing out that the traditional experience is perceived as a commodity and is not intrinsic to current Indigenous ways of life. The side effect of obtaining advanced medical knowledge and technology is a withdrawal of human integrity. Bruyere believes that birth is one of the

most sacred ceremonies and to dehumanise this process does nothing to improve the growing Indigenous maternity discrepancies (2012).

Today, there are significant disparities between Indigenous and non-Indigenous populations. For example, Indigenous women are more likely to have preterm babies (less than 37 weeks gestation), lower birth weight babies and do not attend or seek antenatal support in comparison to their non-Indigenous counterparts (Auger et al., 2012; Luo et al., 2004). In Quebec, Inuit babies are four times more likely to die before their first birthday compared to non-Indigenous women in southern Quebec (Luo et al., 2004). With inferior perinatal outcomes and the implementation of government birthing evacuations policies, higher numbers of Indigenous women have to leave their communities in the Northern Territories to birth in specialised maternity services in the southern urban areas (Vang et al., 2018).

Birthing Evacuations of Indigenous Mothers

According to Jasen (1997) Indigenous elders, community members, cultural activists and some health practitioners have criticised the evacuations of mothers to birth in the main centres as “a colonialist strategy that disregards and disrupts Indigenous knowledge, cultural practices, and healthcare approaches” (Vang et al., 2018, p. 1860). Indigenous people in Canada still live with the trauma of colonisation, which included the removal of Indigenous children from their homes to residential schools that were established from 1870 onwards and funded by the Canadian government’s Department of Indian Affairs. Stories have been told of children suffering horrific abuse and all family ties being severed in order to turn the Indigenous children into civilised citizens of the Canadian society (Kuran, 2000; Truth and Reconciliation Commission of Canada, 2012). Many generations of Indigenous children endured forced residential school attendance, which established distrust between many Indigenous and non-Indigenous populations, and this remains prevalent in today’s generation and hinders relationship and effective communication with medical professionals (Smylie, 2001).

O’Neil and Kaufert (1990) wrote *The Politics of Obstetric Care*, and specifically discussed the Inuit peoples experience. They argued that the Inuit birthing experience

has seen similar changes to maternity practices for Māori and American Indians. Birthing went from home with the family to birthing with midwives in community clinics or birthing homes to birthing in hospitals with physicians with a loss of crucial Indigenous health and spiritual practices along the way.

Routine evacuations since the late 1960s, as mentioned above, were seen by the Department of Health and physicians as a practical response to reduce maternal and infant mortality rates for First Nations and Inuit women living in rural and remote areas of Canada. Douglas (2006) claimed that government policies were written to support the medical evacuation of Indigenous women from approximately 37 weeks gestation to tertiary care hospitals. Birth evacuations were also perceived as being a way to improve perinatal outcomes, making advanced obstetric care accessible to Indigenous women (Brown et al., 2011; Chamberlain & Barclay, 2000; Cidro & Neufeld, 2017; Kornelsen et al., 2011; Olson, 2017). Specialists and facilities to manage high-risk pregnancies are only available in particular cities in Canada, therefore Indigenous women diagnosed with high risk pregnancies had to leave their remote communities to access appropriate medical care. Though, in some communities, regardless of whether the women were of high or low risk, they were still evacuated due to the unavailability of maternity services (Vang et.al, 2018). Brown et al. (2011) and Chamberlain & Barclay (2000) acknowledged that some Indigenous women concealed their pregnancies from authorities to avoid being evacuated and others did not report their births.

A uniform birth evacuation policy under Health Canada was actioned in 2012, as a practical means to reduce high rates of First Nations and Inuit maternal and infant mortality and provided Indigenous women access to “advanced obstetric technology”, yet arguably this access also further embedded the medicalisation that had been occurring since the early 20th century (Jasen, 1997; Vang et al., 2018, p. 1860). O’Neil and Kaufert (1990) explain that transferring women out of their community to have their babies has created barriers and disruption for over 50 years. O’Neil and Faufert (1990) write that the loss of knowledge and ability to be equal has led to a sense of worthlessness that shook the essence of the First Nation and Inuit cultures.

Vang et al. (2018) completed a qualitative study examining the interactions between patient-provider for Indigenous evacuees from the northern Quebec to the Valley

Hospital for pregnancy-related complications or childbirth. Their research supports that Indigenous people from the communities and healthcare professionals also shared their frustrations that childbirth evacuation is a “colonialist strategy that disregards and disrupts Indigenous knowledge, cultural practices, healthcare approaches” (p.1860). Previous studies on childbirth evacuation have acknowledged how profound childbirth evacuation can be on the Indigenous women and their families. Evacuations enforce cultural isolation and can be detrimental on a women’s mental wellbeing (Vang et al., 2018). However, as long as there is a lack of maternity practitioners and maternity services in the remote areas of northern Canada, childbirth evacuations will continue to take place (Cidro & Neufeld, 2017; Douglas, 2006; Jasen, 1997; Vang et al., 2018).

Cidro and Neufeld (2017), Lawford et al. (2018) and Olson (2017) argue that birthing away from one’s community has been associated with social and cultural isolation, which has a significant impact on a woman’s “psycho-social wellbeing” (Vang et al., 2018, p.1860; SOGC, 2017). Research such as that produced by Van Wagner et al. (2007) shows a correlation between birth evacuation and substance use and poor diet for the evacuated women. In addition, their children left at home often suffer from the absence of their mother, a heightened risk of having no childcare cover and the financial strain from the loss of the mother’s wage coming into the home. First Nations and Inuit women have also expressed in studies that they were further burdened by hospital bureaucracy as they felt demoralised by some of their medical encounters, and were not able to build a trusting relationship with their medical providers, given the short medical visits dictated by hospital policy as opposed to the needs of the patient (O’Driscoll et al., 2014; Dugdale et al., 1999; Ha et al., 2010; Vang et al., 2018).

As long ago as 1968, a series of meetings in the Keewatin communities of the Northern Territories discussed the issue of evacuation. The argument for evacuating Inuit women was to allow the physicians to monitor them and, with improved communication systems, this also aided the nurse to be able to seek assistance and help quicker. While there are benefits to hospitals and larger facilities in terms of care, the cost is felt locally. Effectively, the provision of services at nursing stations in remote aboriginal communities could not compete with those in southern Canadian hospitals. Overall, it was understood by the Inuit in attendance at this particular series of meetings that their understanding and knowledge of birth was not valued. Yet, those who had specialist midwifery knowledge within the Inuit community were regarded highly. They passed

on their knowledge about pregnancy and birth preparation to their daughters or other women in their community. When this role was taken over by health professionals elsewhere, it had a detrimental impact on the Indigenous community. They were losing more than their birthing practices. They were also losing the value of distinctive roles within their cultural community. A traditional midwife who practiced in Keewatin communities in the Northern Territories also emphasised what profound effect the evacuation process had on labouring women:

It is demeaning to a women to take her rights away, in a sense killing one of the reasons for living, for her purpose was to help with birthing, and birthing was a part of a woman's responsibility, and when you take responsibility away from a person, she becomes a worthless person (Handwerker, 1990, p. 66).

Another related concern has been the lack of autonomy Inuit women have when entering the hospital to birth. If they require fetal monitoring, their mobility is restricted, and they feel they have no control over their birthing position. Instead of feeling empowered by the birthing experience, many have felt disassociated and sometimes demoralised by the Western maternity model of care (O'Neil & Kaufert, 1990). O'Neil and Kaufert (1990) describe traditional childbirth for Inuit as a community event that entailed a sharing of historical stories weaving the child's genealogy into place, verbalising their hopes and goals for the child in order to lay a pathway for the child to come forth. The Inuit's perception of childbirth as reported in these Keewatin meetings was a communal event, not an isolated occasion as experienced in the southern hospitals.

The travel out of town for services has been researched and it was reported in an anthropological study of childbirth in the 1980s undertaken in the Kivalliq region (Nunavit, north Canada) that traveling for maternity care is disruptive to Inuit families and society because the mother is away for an extended period of time (Balkissoon, 2018; O'Neil et al., 1990). This study highlights that Inuit identity is closely associated with the place of birth. In order to preserve this cultural connection, the idea was to establish more community birthing centres, yet the Rankin Inlet Birthing Centre highlights that community-birthing centres need a stable base of Indigenous staff. They struggle to provide competing care with the more substantial maternity services situated in the larger towns or cities (Douglas, 2010).

A representative of the National Aboriginal Council of Midwives stated:

...reclaiming these practices that are ours is really profound, I think it goes beyond avoiding evacuations. It's a much deeper, more profound revitalisation and reclamation. It's becoming self-determined again (2018, n.p).

Many mothers have felt their cultural knowledge and practices have become devalued. Problems are compounded when they are required to travel long distances to access maternity care, and they have experienced a lack of autonomy throughout the birthing process (Douglas, 2010; NAHO, 2008).

Marlis Bruyere (2012), of the Couchiching First Nations, argues that there is a place for both Western scientific medicine and traditional values and ceremonies. Bruyere believes it is time for Canadian maternity hospital managers and administrators to develop a greater appreciation of aboriginal cultural needs and actively include cultural birthing practices into their maternity services to improve the Indigenous birthing experience.

The emotional and cultural impacts of transitioning from birthing at home to in the hospital environment for First Nations and Inuit mothers has been greater than perhaps mainstream maternity services first realised. Providing maternity services and care in urban centers to families from more remote areas has come at a cultural cost of leaving behind their families and their birthing traditions. Rural nursing stations attempted to meet the needs of Indigenous mothers and their families living on reserves. Nonetheless, the establishment of remote nursing stations for communities who could not afford medical treatment was not an easy accomplishment. This next section further examines the establishment and achievements of the Canadian pioneer nursing stations that, on the one hand, were considered dynamic, but, on the other hand, these stations struggled to properly understand and meet the needs of their Indigenous clientele.

Canadian Nursing Stations

From the 1920s, the Canadian Red Cross established nursing stations in remote rural areas of Canada primarily to address and provide for the health of mothers and babies.

Nursing stations offered aid in areas with no physician, and for those who could not afford medical treatment. One hospital-trained nurse under supervision of a regional general practitioner often ran the stations. Due to the remoteness of these locations, solo nurses were required to do whatever they could to help those coming into the station. This included birthing babies, minor surgery and health education. Nurses were able to provide needed antenatal and post-natal education and advise on care through childhood diseases. Nursing stations provided some relief at the start of the twentieth century in reducing the high maternal and infant mortality rates in Canada.

The stations were often in either converted houses or sometimes rail carriages, offering a few inpatient beds, but nurses' roles were considerable and extended well beyond the physical structures of the stations. Nurses often provided care by traveling around on foot, dog sled, horseback and rail carriage to get to those unable to make it to the station (Benoit & Carroll, 2005; Glassford, 2017; Lux, 2016; Oppenheimer, 1983). Their compassion and commitment to their profession and those they served was admirable, but over the decades the ability to secure Canadian staff became difficult. From the 1960s, the stations were predominantly staffed with foreign nurses (mostly from England) and midwives. The midwives were under the direction of the Ministry of Health and not the community they were serving. Initially, the earlier English midwives would attend home births if they were invited to assist the family, but this was soon stopped, and women were encouraged to birth at the nursing station with an Inuit midwife. Eventually, birthing in nursing stations was discouraged altogether and some Inuit midwives were threatened with legal action if they assisted women to birth (Pauktuutit Inuit Women of Canada, 2019). Indigenous communities began to perceive the nursing stations as colonial tools that emulated government policy and not the voice of the communities they catered to and thus stopped utilising these services (Benoit et al., 2012, 2015).

Station nurses and midwives began to be criticised for their lack of sensitivity and awareness of the colonial impact on the health of Indigenous cultures. When clans were uplifted from their homes and forced to resettle in new and different environments, the station nurses and midwives struggled to understand the effort it took for Indigenous women to cope with their adverse environments. It took a long time for non-Indigenous midwives to obtain a greater understanding and appreciation of Indigenous people's beliefs and values. The irony was that when they finally became more knowledgeable

about the local Indigenous community, the nurses vacated their employment for various reasons. Consequently, the high turnover of staff in nursing stations was a common reality (Benoit et al., 2012, 2015; Canadian Nurse, 2018).

The 1966 Annual Health Report on the Northern Territories found that in 1964 approximately 66 percent of Inuit births occurred outside both the hospital and nursing station. However, by 1968 this figure was significantly reduced. Ongoing pressure by government to birth in a hospital was sufficient, with a rise of 97 percent of Keewatin women giving birth in a hospital or a nursing station by 1968 (Annual Health Report on the Northern Territories, 1968). The medical profession in Canada, according to O'Neil and Kaufert (1990), worked with little opposition to dominate the control over childbirth. With low midwifery numbers and no formalised advocacy collective, the medical profession was able to grow their hold over the delivery of maternity care. It was evident in their writing that the northern midwives were few and those that were there were isolated (Annual Health Report on the Northern Territories, 1968; O'Neil & Kaufert, 1990).

Throughout the 1970s, eligibility for women to birth in the nursing stations became stricter and by 1980 government policy dictated that no births would take place at any of the nursing stations (Elliott et al., 2008). Therefore, more midwifery training programmes needed to be established and funded to provide for the larger numbers coming through the hospitals, including the overflow from the now defunct nursing stations (O'Driscoll et al., 2011; Olsen & Couchie, 2013).

The original concept that the nursing stations exemplified appeared to be one of meeting the health shortfall for remote Indigenous communities on reserves. Yet, over time, government departments like the Ministry of Health believed they had solutions to addressing Indigenous health, however, it was questionable how much heed the Ministry paid to the Indigenous communities on what they believed they needed. As the nursing stations began to dwindle during the 1980s, in service capacity and numbers, the development of formal midwifery education commenced in the 1990s. Nurses from the nursing stations dispersed to different areas and the desire was to train more midwives to make up the shortfall within the hospital settings (Elliott et al., 2008; O'Driscoll et al., 2011; Olsen & Couchie, 2013). Midwifery education has aimed to seek autonomy from the obstetric fraternity as health practitioners in their own right,

and for traditional birth attendants to be acknowledged for their customary expertise in the maternity field.

Midwifery Education in Canada

The Canadian Association of Midwives (CAM, 2019) report that there are currently seven midwifery education programmes operating in Canada. Students can enter these four-year Bachelor programmes directly with no prior nursing qualifications. The midwifery education programmes facilitate the midwifery examinations that are recognised by their local midwifery authority. The Ryerson Midwifery Education Programme in Ontario welcomed the Black, Indigenous, People of Colour (BIPOC) mentoring programme for any student who self-identified as a person of colour. The BIPOC project raises solidarity among the Black, Indigenous and People of colour to “undo Native invisibility, anti-Blackness, dismantle white supremacy and advance racial justice” (McGee & Kanagasingam, 2019, n.p). Any midwife or student living and working in Canada can take part in the BIPOC programme regardless of what Midwifery Education Programme they are attending. The goal of instigating a mentoring programme is for retention of BIPOC students through to their graduation, and mentoring also promotes professional skills that grow resiliency amongst the students and practicing midwives. The Canadian Association of Midwives (CAM) (2019) also concedes that growing a culturally diverse midwifery workforce will encourage improved health equity amongst the Canadian population, and cater to the Indigenous communities. The BIPOC students had a lower attrition rate and greater satisfaction through being mentored as students and graduate midwives (CAM, 2019).

Before the 1980s, midwives were a rare profession. Medical and nursing practitioners in hospitals delivered the majority of maternity care (Benoit et al., 2012, 2015; Nestel, 2015). Midwifery education in Canada now takes place at university as a four-year Bachelor of Midwifery degree. There is also a funded midwifery-bridging programme to encourage more students to enter the midwifery degree. However, not all midwives train via the university programme. In some Inuit communities, for example, Inuit women receive midwifery education within their communities.

It was not until the 1990s, when midwifery became legally documented in Canadian provinces and territories, that the Canadian government implemented legislation to regulate midwifery. This was a major step towards the autonomy of the midwifery profession. Another constructive step in this sovereignty process is the extension of training to Indigenous reserves. However, the inclusion of midwifery training to members of Indigenous reserves has unfortunately not been universal or systematic. Midwifery training for First Nations and Inuit, therefore, continues to be ad hoc in locations and provision.

Aboriginal Midwifery Education

By the mid-20th century, the devastation of colonisation, the loss of land and language repressed the values and traditional practices of the Indigenous people. Oral traditions were diminishing and the battle to keep their knowledge was consuming. It continued to be an uphill battle as grandmothers and great-grandmothers worked tirelessly to protect birth knowledge. Therefore, the pilot training of Indigenous midwives brought great relief to the Inuit, and First Nations elders, the resurgence of maternity knowledge gave way for the resurgence of cultural strength and pride; a rebirth of the Indigenous culture and an expression of sovereignty (Tabobonding et al., 2014).

An Onkehonwe midwife and traditional practitioner relayed the following about the cultural significance of retaining traditional birthing knowledge:

I have been given the gift as a knowledge keeper around the ceremony of birth and understand our role in creation and the life cycle. I live and carry responsibility that guides me to protect the sacred space. By reclaiming the sovereignty of birth we will strengthen ourselves, families, clans, community and nation (2016, p.13).

There are currently 65 Indigenous midwives in Canada, and 31 midwifery students are accepted into midwifery programmes throughout Canada every year, according to the Canadian Association of Midwives (2019). A discussion paper by the National Aboriginal Council of Midwives (NACM), who actively encourage the restoration of midwifery education and midwifery services in Canada's Indigenous communities,

states that the lack of equitable rights to culturally appropriate midwifery care is having an impact on the health of infants in comparison with the rest of the Canadian population. NACM claims that Indigenous care is “best practice” for maternity care in Indigenous communities across Canada (2016, p. 3). NACM also believes that midwifery services within the Indigenous communities literally and physically returns birth back to the home. The aim is towards more Indigenous maternity provision and Indigenous midwives to work within their Indigenous communities “supports the regeneration of strong families” (2019, p.3).

The key concerns for Indigenous midwifery are the many obstacles that include lack of funding, lack of midwifery support and jurisdiction restrictions. Two of the paper’s recommendations to the Treasury Board of Canada were firstly, to improve midwifery services on First Nations reserves. Secondly, to develop an occupational classification for midwives which will allow for the employment of midwives to work under federal jurisdiction on First Nations reserves, and thirdly, for the Canadian government to increase the number of Indigenous midwives in the workforce so that there are more available to assist their communities. NACM (2016) have called on a collaboration between government and education providers to supply Indigenous midwifery training programmes in Canada that utilise local Indigenous knowledge, further develop Indigenous models of maternal and infant health, and place midwifery training programmes in Indigenous communities that do not currently provide training.

An example of an Indigenous midwifery training programme that has been in place since 1986, is the Inuulitivik Midwifery Education Programme. This programme comes under the Innulitivik Health Centre, which aids seven maternity services that cater for the Indigenous communities in Nunavik. The Innulitivik Midwifery Education Programme was primarily established from the community advocating against women being evacuated from their reserves in remote areas, and for the return of Inuit customary midwifery practices. Their model of midwifery education has since been recognised across Canada and globally as an exemplar of how Indigenous midwifery can be taught to not only grow the Indigenous midwifery workforce but to keep the old Indigenous knowledge alive (Benoit, 2001; NACM, 2016).

Local birth centres known as “maternities” employ students to learn under midwife mentors. The students are included into the midwifery team and are taught the Inuit

customary birthing practices alongside international midwifery standards. Their training is consistent with midwifery education programmes facilitated by Canadian Universities. The graduates from the maternities are licensed under the Quebec governing body of midwifery (Epoo et al., 2012). However, despite research that highlights improved Inuit birthing outcomes and strong approval by the National Aboriginal Health Organisation, the majority of Indigenous women continue to be evacuated from their remote locations and taken to more centrally based hospitals to birth their babies (Kornelson & Gryzbowski, 2004; Smylie et al., 2001; Van Wagner et al., 2007, 2012). More government support and funding are required to sustain Indigenous birthing centres and to provide more Indigenous midwifery education for midwifery students and Indigenous midwives to advance their knowledge and skills as practitioners and teachers (Epoo et al., 2012).

Although the Indigenous midwifery services are small in number across Indigenous communities, their intention and integrity to serve their people has kept them pursuing funding to maintain their Indigenous midwives and sustain their maternity care. Another example can be found on the Mohawk Reserve in Akwesasne on the borders of Quebec and Ontario. They facilitate a midwifery programme and provide education and training on Indigenous healing and rituals for Indigenous midwives (Benoit, 2001; Wheeler, 2017; Van Wagner et al., 2007).

In 1996, a training programme for Indigenous midwifery students commenced in Ontario. This programme provides for the members of the Six Nations Reserve and, as long as the Indigenous midwives provide maternity services for Indigenous families, they can practice on and off the reserve (Association of Midwives of Newfoundland and Labrador, 2005). Irnisuksiiniq is an Inuit Midwifery Network that shares information about maternity care services with Inuit maternity care workers and Inuit midwives who provide a combination of traditional and contemporary models of midwifery care. In Salluit Que, Quebec, the third Nunavik maternity centre was established in 2004, following the first in Puvirnituk in Hudson Bay in 1986. The second maternity centre was built in the 1990s close to the first in Inukjuak. All centres employed mostly Inuit midwives and allied staff that practice with, and teach, traditional birthing practices to families and mentor Indigenous midwifery students (Epoo et al., 2012).

An important National non-profit association for Inuit Women of Canada was established in 1984, called Pauktuutit. This organisation represents Inuit women on Indigenous issues, including the provision of advocacy and support to Inuit women and their families. Pauktuutit also conducts Inuit Midwifery research, and between 1992 and 1993 they interviewed 75 Inuit elders and collected over 500 birth stories. The data from this research continues to guide Indigenous birthing resources given to pregnant mothers and their families (NAHO, 2008).

Another issue that impedes Indigenous midwifery, is the inadequate cultural training of the medical profession. This, according to O'Neil and Kaufert (1990), creates a misunderstanding of the valuable input Indigenous midwives provide in the maternity arena. Therefore, the medical profession without education in cultural issues perpetuate the bias of their seniors, that if a midwife attends a birth then it is not considered medically attended and somewhat of a lower standard of care. A disconnect between the professions highlights a power imbalance between the doctors and midwives. It is similar in the relationship between coloniser and colonised; both provoke a sense that one culture knows or thinks it knows better than the other.

The Canadian midwifery workforce

McCracken (2015) reports that the stereotypes of midwives held by some physicians from the early 1900s onwards, as being largely “untrained and unhygienic”. This did not stop certain provincial governments sanctioning the use of nurse-midwives in remote areas to deliver needed maternity care to these communities long before midwifery was regulated (n.p). However, when midwifery in Canada commenced the regulation of the profession, remote areas often populated by Indigenous peoples were most affected.

Midwifery has been a regulated profession since the 1990s in some provinces in Canada after lobbying for many years to the government for better maternity care. Canada was one of the last nations to acknowledge midwifery as a legal profession. Regulating midwifery in Canada has been a slow and ad hoc process throughout the provinces of

Canada and, therefore, the provision of funding for health and midwifery services has varied greatly too.

Interest in natural birthing from the 1960s to the 1980s helped establish the Home Birth movement. Subsequently, this movement, in turn, highlighted the work and social acceptance of midwifery involvement in birth across the country (McCracken, 2015; Plummer, 2000). Yet, the greater interest in natural birth did not deter the majority of women from delivering their babies in regional hospitals with physicians, obstetricians and obstetric nurses in attendance (Plummer, 2000). For example, in Ontario during 2017, midwives attended six percent of the births and, of these births, 83 percent were in hospital. There still appears to be misconceptions and perhaps mistrust on the expertise of midwives in times of birthing emergencies and thus women seem to prefer to birth in hospital in case anything adverse were to take place, rather than trusting their midwife to deliver the appropriate care and guidance in all birthing situations (Canadian Association of Midwives, 2019; Fairbrother, Stoll & Schemmes, 2012).

Regulated midwives can work independently within small group practices, they can access blood and ultrasound services, and they can prescribe certain medications. The Canadian Midwifery Regulators Council was established with a network of regulatory authorities based in provinces and territorial areas throughout Canada. They set the Canadian midwifery competencies and national midwifery standards of care, administer the midwifery registration examination and approve the midwifery education programmes (CAM, 2019).

The core principle in the Canadian model of midwifery is that it is women-centred care, and the mother is the primary decision-maker in her care (Cameron, 2005; Turnbull et al., 1991). However, a major problem still exists in Canada, which is that the demand for midwives overall far outweighs their supply (Cameron, 2005; Turnbull et al., 1991). The Indigenous midwifery workforce shortage in Canada restricts the ability to reestablish Indigenous midwifery. There is a need to increase the Indigenous midwifery education opportunities and, in particular, community-led programmes with ongoing devoted funding that will eventually lead to more equitable maternity outcomes and the restoration of Indigenous midwifery provision (Balkinsoon, 2018, Association of Ontario Midwives, 2019).

Ontario Midwifery and Maternity Services

Midwives in Ontario are self-regulated by the Canadian College of Midwives and achieve their midwifery degree after four years of study. The model of midwifery care adopted in Ontario is one of continuity of care, which is shared between approximately four midwives who take full responsibility for a woman's care throughout her entire pregnancy and the first six weeks post birth. The midwives in Ontario work in a community-based practice and can work in both the hospital and community. One of the difficulties facing midwives in Ontario currently is the restricted amount of midwife-facilitated births they can do in hospital and this figure is dependent on the allocated funds from the hospital budget. Therefore, the waiting lists for midwives in Ontario are long. The number of requests for midwives that are turned down on a yearly basis is approximately 27 percent due to their inability to continue their care into the hospital setting. Fortunately, the government does cover midwifery costs for all women in Ontario (CAM, 2019).

Indigenous midwifery in Ontario has been an ongoing project for over 20 years, according to the Indigenous midwives in attendance at the Indigenous Midwifery Summit in Ontario in 2019. They acknowledged funding already received for Tsi Non: we Ionnakeratstha Ona: grahsta and the Six Nations Birthing Centre and The Association of Ontario Midwives has also funded the employment of a policy analyst and a director. These positions work specifically on returning and growing Indigenous midwifery in Ontario.

In 2016, the Ontario government committed to working with the First Nations and Indigenous communities on a number of fronts outlined in their report titled, *The Journey Together: Ontario's commitment to Reconciliation with Indigenous Peoples* (2016). The aim of the government was to work with First Nations and Indigenous communities to address cultural issues, improve equality and remove barriers that have impeded the growth of the Indigenous people in Canada since they have been colonised. The government dedicated \$250 million over a three-year period to fund programmes and initiatives that work towards reconciliation. The Ministry of Health also invested in the Indigenous Midwifery Programme with money allocated to development grants

and proposals for practices. This was acknowledged by the Ontario Midwives Association as a strong government commitment to the reinstatement of Indigenous midwifery (Association of Ontario Midwives, 2019).

The Ontario government, in 2017, provided provincial funding towards Indigenous midwifery and has established Indigenous midwifery programmes, and aims to offer culturally appropriate care to a number of Ontario Indigenous communities (Gemmell, 2017). Funding was also provided to the Shkagamik-Kwe Health Centre, who hired two Indigenous midwives. This is a three-year investment and will see up to 40 Indigenous women receive maternity care (Gemmell, 2017). Indigenous midwives in Ontario can still work legally without being registered via the Canadian College of Midwives due to the exception clause within the Midwifery Act of 1991. This clause came into action in an amendment to the Act and to the Regulated Health Professions Act in 1994, bypassing the need to have a university degree to be registered with the College of Midwives as long as Indigenous midwives had the equivalent skills, as acknowledged by their own communities, to deliver the work.

Indigenous Maternity Services

Canada currently has 13 midwifery practices and initiatives that have been primarily established to meet the needs of the local Indigenous communities. Some provide maternity services autonomously, and others are Indigenous services offered under the umbrella of mainstream maternity or general health service (Cameron, 2005; NAHO, 2008; Rogers, 2014). For example, the Rankin Inlet Birthing Centre, Nunavut, was established in 1993 and Vasiliki Douglas (2010), an Inuit community midwife, explained that this particular birthing centre was originally meant to be the pilot for many other similar centres positioned throughout the northern territory of Nunavut in Canada. Douglas's analytical historical study of the Rankin Inlet Birthing Centre in 2007 concluded that the centre is a successful and valuable service, but it also reiterated that Rankin's success had not been without its challenges.

The Rankin Inlet Birthing centre sits in a precarious position, competing for Indigenous clientele. Yet, many local families have preferred to undertake the trek to southern

hospitals (such as Churchill and Winnipeg) to birth their babies instead, largely because of greater access to technology and possibly also because mothers are conditioned to have less faith in their Indigenous services. There appears to be some truth to this concern, as it has been reported that the Indigenous service has fallen short in providing local midwives (Douglas, 2010). The initial intention was for the Rankin Inlet Birthing Centre to employ Indigenous midwives, but the reality has been that they only had two Indigenous maternity care workers and the rest of the team were from southern Canada working on a rotating schedule. Midwives and other key staff members were not from the area, and this appeared to create barriers to trusting relationships between the staff and the community. Non-local midwives and staff shortages meant that the birthing centre was forced to shut down until more staff could be recruited temporarily. Effectively, the Rankin Inlet Birthing Centre appeared to be struggling to meet the needs of the Indigenous community, with an unstable workforce due to the remoteness of its location (Douglas, 2010). The Centre had a long-term plan that included training and employment opportunities for Inuit midwives, but this had not eventuated. Originally, the Rankin model was to be extended into other communities but with difficulties apparent in this community, trying to replicate this in others may be equally problematic (Douglas, 2010).

The Six Nations Maternal and Child Health Centre in Ohsweken, Ontario (Tsi Non: We Ionnakeratstha, meaning the place where they will be born) opened in 1996. Together with the Seventh Generation Midwives Maternity Service in Toronto, established in 2005, it provided access to professional Indigenous midwives amongst their communities. Both services wrap around the families of their clients, providing them access to other necessary social services, such as housing and travel assistance. In Toronto, 87 percent of the Indigenous adult population lives in poverty (Balkissoon, 2018). The Six Nations maternity service provide the three-year midwifery training that combines academic, practical and traditional knowledge. Their midwives have the authority to practice through the Band Council of the Six Nations reserve and, although funded by the Government of Ontario, they are accountable to their community. Another point of difference is the guidance received by their elders, who sit alongside the midwives, teaching parenting skills and traditional ethics that include traditional maternity ceremonies (Davis-Floyd et al., 2009).

Kupu Whakarāpopoto (Summary)

Creation mythology remains embedded in the genetic and environmental foundations of Indigenous peoples and has created a strong platform to return to in times of reclamation of their autonomy and remembrance of traditional practices that uplift them as a people. Birthing in traditional times was a ceremonial celebration shared with the community. Traditional midwives were deeply respected and known as carriers of cultural knowledge.

Historical statutes passed in Canada, for example, the Indian Act in 1876, continue to impact on the identity and expression of cultural ceremonies of the First Nations. Other statutes restricted access to land and resources and reduced the Indigenous collective's autonomy over their reserves and, ultimately, themselves. Not only did the First Nations peoples become displaced, but so too did the birthing of their children on their ancestral lands; instead they were evacuated from their communities to birth in hospitals many miles away from their families and their customary birthing practices.

The slow and ad hoc establishment of Indigenous midwifery programmes commenced after the launch of mainstream midwifery training programmes throughout Canada. The midwifery profession was regulated in the 1990s but the demand for their services far outweighs the supply of midwives. Discrepancies between Indigenous and non-Indigenous infant and maternal maternity outcomes continue to be an issue. Traditional midwives have recently gathered belated recognition as vital contributors to the midwifery-training curriculum and to the maternity profession as they work alongside with and independently of medical practitioners. More work is required to sustain and grow the Indigenous midwifery workforce as First Nations and Inuit population predictions forecast a continued youth-dominated population with greater capacity to produce more offspring.

Some see the medicalisation of birth in the First Nations and Inuit peoples' culture as a dominant attack on their Indigenous identity. The departure from the reserves to birth in hospitals has had, and continues to have, a commanding influence on a culture battling to reclaim their identity, their language and to keep their land reserves intact and serviced. The removal of the lay midwife role or birthers within the Indigenous

community has tainted the value that Indigenous women have played within the birthing realm and has also steamrolled the loss of traditional birthing knowledge (Benoit et al., 2012, 2015; Cidro & Neufeld, 2017; Olsen, 2017; Vang et al., 2018).

Overall, there is an impression that there is a stronger desire in the mainstream to cater for the Indigenous communities. This is suggested by opening a few funding pathways to allow for Indigenous birthing centres to operate with greater support. More midwifery education programmes are working on luring Indigenous midwifery students into training to grow the Indigenous midwifery workforce. What remains a concern, is keeping the momentum of interest in Indigenous maternity knowledge, and the respect for, and value of Indigenous midwives at the forefront of the government agencies that support all components of the midwifery sector. The good tide has come in, but it could easily subside and delay the progress of what is needed and should be granted for Canada's Indigenous communities.

With a rise in births predicted, there is need for more primary health services in the heart of the Indigenous communities that include customary birthing practices. This approach will then reduce the need for evacuations to urban hospitals, ultimately benefiting families who may remain intact and together as they welcome new life. Keeping birth in the community also enhances the chances of retaining cultural practices and passing this knowledge on to the next generation.

The learning gained from existing Indigenous maternity services in Canada, such as the Six Nations Maternity Health Service and the Seventh Generation Midwives, along with the earlier Indigenous training schemes, is encouraging for other Indigenous collectives eager to reinvigorate their birthing traditions in their communities. Government statutes debilitated the Indigenous people in Canada and Mexico. The drive for assimilation and civilisation of Indigenous people by the governing culture resulted in disempowerment and denial of cultural values, beliefs and practices. Over generations, Indigenous people lost access to their lands, their tribal or clan governing structures, their food sources and, to a great extent, over the expression of their cultural uniqueness. The legacies of colonialism continue to dictate how and when we can use our cultural practices to work with our people (Benoit et al., 2012, 2015; Canadian Nurse, 2018; Elliott et al., 2008). Gonzales (1985) highlights that traditional knowledge

has an essential place in contemporary society and provides strength and options within a natural process, such as birth.

Traditional birthing assistants or traditional midwives carried traditional birthing knowledge and practices. They taught families about creation stories of old alongside the elders in the communities, they showed the women and their families how to care for the pregnant woman and how to prepare for birth. They also guided families to celebrate the births and conduct the rituals associated with new life in their communities. Nursing stations, government legislation concerning the Indian reserves and the Indian status, and non-Indigenous midwifery regulations eroded the significant role traditional midwives had in the management of Indigenous wellbeing. Therefore, reclamation of customary birthing practices firmly sits in the return of traditional midwives, the holders of old creation knowledge.

For Ngāi Tahu, the role of customary knowledge holders lay across a number of specialists within the hapū (subtribe). Tohunga were iwi leaders who carried specialist roles often in specific vocations, often wise across many disciplines but stronger in a particular knowledge arena. Overall, the similarities between Ngāi Tahu birthing traditions and the First Nations and Inuit peoples were simultaneously disempowering and empowering for me as a Kaupapa Māori researcher. Knowing that other Indigenous cohorts had suffered similar fates was disturbingly comforting but equally upsetting. The loss of customary birthing practices has occurred across those collectives because of colonisation, dishonesty, disenfranchisement and grave injustices to the culture through debilitating legislation and socioeconomic disadvantages. First Nations and Inuit peoples have suffered the same losses, and like Ngāi Tahu, they are in a similar position of minimal access to Indigenous maternity providers and midwives.

The knowledge gained in this Indigenous comparative review has provided a sense of shared experience and a window out of my isolated Indigenous research bubble. However, it has also highlighted a profound sense of loss; a loss of Indigenous birthing knowledge and cultural practices that are essential for Indigenous wellbeing. First Nations, Inuit peoples and Ngāi Tahu are all in a state of reclamation right now and are contending for their cultural values and practices to be returned and accepted. It is challenging proving to mainstream maternity services and midwifery training establishments that the reclamation of Indigenous birthing knowledge and practices is

a potent intervention; it is the survival of a culture, family lineage, tribal and individual identity. Without these core components, what remains of a culture?



8

Hākari

Ko te whakamutunga kōrero me te
matapaki kōrero a muri

Ko te Matapaki Kōrero

The conveyance of Ngāi Tahu mātauranga, whakapapa and history through ritual and practice relevant to conception, pregnancy and birth has largely been forgotten. However, most importantly they have not been lost but stored within the formalities of tangihanga. Although tikanga and kawa for tangihanga have altered over time with the introduction of other faith systems and social influences, the core components remain. Childbirth rituals still appear to be present within the verses of karakia, waiata, whakapapa kōrero, tikanga and kawa that we hear recited at tangihanga today. It is a relief to know all is not lost, and it also provides a starting point to reinvigorate Ngāi Tahu customary birthing practices alongside the active recruitment of Ngāi Tahu into midwifery training.

We can learn from the First Nations and Inuit peoples, who have preceded us with their journey of reclaiming traditional knowledge within maternity provision; both in hospital settings and primary birthing facilities in their communities. What the First Nations and Inuit peoples have found with the restoration of their customary birthing practices, is that knowledge grows knowledge. Community elders return to these settings honoured for their wisdom and the transgenerational exchange of knowledge. Moana Jackson (2017) acknowledges the qualities required to advocate change for the betterment of Māori in his speech to Māori health practitioners. He is aware of the bravery and courage sometimes needed to do this. First Nations and the Inuit peoples have been brave in establishing stand-alone Indigenous maternity services and Indigenous midwifery training, and they have the courage to keep pushing their governing bodies for the sustainability of these services as a human right (Bryere, 2012; Cook, 2003; Gonzales, 2012; Ramsden, 1990).

Approach to research

This thesis embodied kaupapa Māori theory as a methodology. Kaupapa Māori best aligned with the underpinning focus of whakapapa, whānau, customary birthing rituals and practices, and the research participants involved. Smith's (1997) principles of kaupapa Māori theory (discussed in Chapter Three, Section 3.1, p.80) emphasised values of tino rangatiratanga and guided the implementation of this research. These principles were threaded throughout the gathering and analysis of information and in the final writing of the thesis. Alongside this matrix lay my wāhine Ngāi Tahu perspective, encompassing over 20 years' experience as a health practitioner and my personal exploration of customary birthing practices with my own births. Korach (2014), states that Indigenous knowledge systems are the heartbeat of Indigenous methodologies. They align themselves by embracing the context, inclusive of land, waterways, bush, home and also kinesthetics and spirituality. Kaupapa Māori research principles offer a decolonizing methodology that frames Indigenous knowledge. The focus is on collective and holistic processes, unlike non-Indigenous methodologies that can have a constant comparison process between dualities, like subject/object or mind/body. The research objective asked the following questions:

1. What is known about Ngāi Tahu customary knowledge and practices and do they remain applicable?
2. What was the contextual landscape in the history of Ngāi Tahu that contributed to the decline in customary birthing practices?
3. What will be required in terms of knowledge acquisition and capacity building in the restoration of these practices?
4. What can be learned from a comparative review of the First Nations and Inuit peoples' reclamation of customary birthing practices in Canada, that can aid a similar return for birthing knowledge and practices for Ngāi Tahu?
5. Would the establishment of a stand-alone kaupapa Māori birthing unit be a beneficial consideration?

The focus of the research then shifted to the training of midwives, with a focus on these questions:

6. Can more Ngāi Tahu birthing knowledge and practices be incorporated into the midwifery curriculum of the two South Island Bachelor of Midwifery providers?
7. How can more Ngāi Tahu be lured into the midwifery profession?

The interviews addressing the future of Māori midwifery concentrated on the current reality for Māori midwives and midwifery students. I explored how Māori midwifery students felt about their midwifery training, as well as their thoughts on greater incorporation of Māori customary birthing knowledge into their midwifery curriculum. I also wanted to investigate an earlier interest of the Canterbury Midwifery Rōpū to explore the establishment of a Kaupapa Ngāi Tahu primary birthing unit in Christchurch. My main line of inquiry was to see whether the data, literature and interviews indicated this was still a positive and worthwhile avenue to pursue.

I collected data from audio, visual and literature archives and gleaned information from pūrākau (stories) about creation and the histories of the iwi Ngāi Tahu. Old waiata and karakia pertaining to creation and childbirth were sourced to gain an understanding of what knowledge they shared about Ngāi Tahu childbirth tikanga. Some of the waiata and karakia came with translations while others needed to be translated with the

assistance of experts in this field. A total of 29 semi-structured qualitative interviews with predominantly Ngāi Tahu participants took place, and I facilitated two wānanga at two Ngāi Tahu marae.

I continued to attend tangi and hui at a number of my marae on the Banks Peninsula, Ōtautahi (Christchurch). Over four years, I absorbed discussions about customary birthing practices and pondered the implications of the research findings for my iwi. I considered the thoughts and actions of my tūpuna – how did they learn this knowledge? Why did they perform these rituals and practices? What greater purpose did these rituals and practices fulfil?

A strong correlation to whakapapa underpinned this research; it was the motivation that initiated the research and was a consistent theme throughout this kaupapa. As a Ngāi Tahu wāhine, many of the pūrākau stemmed from my whakapapa. The utterances from my tūpuna now sit within the Appendices to the Journals of the House of Representatives and Royal Commission Reports. It is also in reverence of whakapapa that I note that this thesis cannot speak on behalf of other hapū and iwi. They, respectfully, have their pūrākau and knowledge pertaining to this kaupapa, and rightfully should be the ones to discuss it. Equally, in respect of whakapapa, this thesis does not claim to speak on behalf of all Ngāi Tahu wāhine and acknowledges the variances between hapū and the individual (O'Regan, 2001).

Again, whakapapa was advocated for in the identification of research participants. They could choose how their kōrero would be recognised rather than anonymising them. Most participants opted to be identified with their iwi affiliations. Pere and Barnes (2001) claimed that confidentiality can be perceived as being culturally inappropriate because being anonymous does not allow participants to whakamana (give respect or honour) the origin of their mātauranga Māori. All but five participants in this research project were eager to have their name and iwi identified in this doctoral research.

The rōpū kaumātua (elderly support group) that agreed to provide tautoko at the start of this doctoral journey dwindled through death from six members to two. The weight of this mamae is hard to fathom, the kaumātua in this rōpū are ambassadors for Te Ao Māori. The remaining matriarchs have been an inspiration and provided unfailing encouragement and guidance. They maintained the “tau” (to be anchored or settled) needed to ensure the thesis had depth and integrity.

I used a reflexive thematic analysis that included the seven guiding kaupapa Māori principles to draw themes and pūrākau from the collated data. I utilised my literature review to compare what was coming through in the data and what was known from the literature. The research data raised the following themes that enabled me to address my thesis questions.

8.1 Section One: Holding onto ancestral knowledge

Telling the whole story

When describing pūrākau (stories) of whānau, hapū and iwi, there is normally a beginning, a time in between and, at a certain point, the pūrākau comes to an end. With Ngāi Tahu birthing practices largely forgotten, the introduction of Ngāi Tahu's pūrākau whānau is missing. Even though tikanga and pūrākau at tangihanga are still occurring, the equilibrium for Māori appears out of kilter, leaning heavily towards “mate” (death). Therefore, if we could reclaim customary birthing practices as an accepted and valid option with appropriate birthing supports, the prospect of recapturing the beginning of our pūrākau ora (life story) will be much more obtainable. Not only the pūrākau but the Māori equilibrium between life and death will potentially sit more firmly in the centre.

Repositories of Kawa

The tikanga and kawa often displayed at tangihanga are similar to customary birthing rituals. The recital of creation karakia and whakapapa, the singing of waiata, the retelling of iwi, hapū and whānau pūrākau, the tapu elements around the tūpāpaku, the nurturing of the whānau pani (immediate relatives to the tūpāpaku), the cleansing of the space and place, the welcoming back of the whānau pani after the burial through a whakanoa process (making the space free of tapu) and a hākari to complete the kawa. The correlation between the two rituals can be surmised, albeit the tangihanga processes we witness today have evolved and do include Christian rituals that have been accepted by some marae as kawa (protocol) (Gloyne, 2020).

Kaumātua research participants remembered that the Māori midwife from their hapori (community) was often the person who washed the body of the tūpāpaku in preparation for their tangihanga. They were also the kaitiaki (guardian) of the whāriki (mats) used for both birth and death (McClean, 2011; Tainui, 2019; Tikao, Ngāi Tahu, 2017). This detail provided another connection between what would initially appear to be two ends

of the life cycle but, in fact, in Te Ao Māori these two definite events in life can be seen through similar kawa as one of the same, or a journey through life and death, death and life (Barlow, 1991; Mead, 2003; Moeke-Maxwell et al., 2013; Ngata, 2005; Pere, 1991).

The life and death continuum are reiterated in creation mythology, such is in the pūrākau of Hine-tītama escaping to the underworld after discovering that her father was her husband. Hine-tītama, ashamed and disgusted, grabbed her daughters and fled to the underworld (Tikao in Beattie, 1920). When her husband attempted to run after her, Hine-tītama directed Tane to return to the world of the living and raise the people. Hine-tītama became the goddess of death, Hine-nui-te-pō. In this state, Hine-nui-te-pō exclaimed to Tane that she would proceed to haul the people towards her abode (towards death): “E hoki e Tane ki te Ao whakatipu mai i a taua hua nei. Tukua ake au ki te pō hei kukume atu.” The two daughters of Hine-nui-te-pō, Tahu Kumea and Tahu Whakairo, stand at Te Whare o Pohutakawa (the house of death) and watch the souls pass through to Te Reinga (the underworld) (Tikao in Beattie, 1920). The final and, depending on the version of pūrākau, favoured exploit of Maui also highlighted the continuum between life and death. Maui attempted to bring immortality to humanity by reversing the life cycle. He attempted to re-enter the birth canal of Hine-nui-te-pō while she slept. Hine-nui-te-pō awoke to the shrill of the tiwaiwaka (fantail), who may have been warning Hine-nui-te-pō or laughing at the ridiculous sight of Maui. Hine-nui-te-pō snapped her legs shut and Maui was no longer (Cowan & Pomare, 1930).

Waiata and karakia, as mentioned previously, are another component of both tangi and whakawhānau (birth) that spiritually prepare the pathway for the pēpi to be born or in tangihanga, poroporoaki (farewell) the wairua of the tūpāpaku (deceased) towards Te Reinga (Barlow, 1991; Mead, 2003). The living and the dead would not normally be spoken about together but one before the other. At the conclusion of the kōrero of death, it is essential that the transition is acknowledged and the realm of Hine-nui-te-pō spiritually closed before entering into kōrero with and about the living (Beattie, 1990; Marsden, 2003; Mead, 2003).

As we reclaim Māori customary practices, we can find relief that the tikanga and kawa of tangihanga can be seen as repositories of some core birthing tikanga and kawa. From

there, the infantry can be regathered and reinforced with specific Ngāi Tahu birthing tikanga and kawa. Murphy (2019) reiterates that:

We should never fear seeking out and renewing ancient rituals, nor evolving new ones to suit contemporary decolonizing and ecological contexts (p. 277).

Forgotten not lost

Ngāi Tahu customary birthing practices have not been completely lost through colonial impact and the hospitalisation of birth, as first alleged at the beginning of this doctoral journey. This thesis has contributed to a more nuanced understanding of what remains of traditional knowledge; finding that customary birthing practices have been forgotten through colonising legislation that created barriers to its use. Our living repositories, such as Ngāi Tahu kaumātua, are limited with their understanding of customary birthing practices through no fault of their own. This knowledge gap is the ramification of te reo suppression in native schools, rural to urban drift and the hospitalisation of birth. Assimilation and discrimination continued to be executed by the many who thought it was better for all to accept Western practices to better themselves (Anderson, 1990; Beattie, 1954, 1994; Bryder & Dow, 2001; Harte, 2001; Stojanovic, 2008).

A glimpse into the past

Māori language in the 1940s, for many Ngāi Tahu tamariki, was spoken behind doors between adults and at formal occasions on the Marae; tamariki in this period were often kept away from the formalities (Diaz, 2017; Pitama, Ngāi Tahu, 2016; Tikao R & W, Ngāi Tahu, 2016). They were aware births were taking place at the kaik (Māori village) and, if able, they would “sneak a peek” at the activities in the wharehau or in a designated birthing room at one of the whare. Some may have come in on the skirt tails of one of their aunties; many played outside and came in either when the baby was born or to assist with the clean-up. Therefore, ritual for these tamariki became what they could glimpse through windows and from hanging around adults before being ordered away. These tamariki became the kaumātua I interviewed for this doctoral study. This

was their context and my reality when trying to extract knowledge that may not have been shared with them (Diaz, 2017; Pitama, Ngāi Tahu, 2016; Solomon, 2017; Tikao, R & W, Ngāi Tahu, 2016). However, all the kaumātua agreed that they would have liked to have known these old practices. They want for their mokopuna and mokopuna tuarua to be proficient and prolific speakers of te reo Māori, tikanga, karakia, waiata, and customary birthing practices, like whenua and pito burial, kaitiakitanga (guardians being given to the pēpi), use of rongoā and natural birth tools that they themselves were either not aware of or not able to execute (Hutchings, Ngāi Tahu, 2017; Ngarimu, Ngāi Tahu, 2016; Solomon, Ngāi Tahu, 2017; Tainui, Ngāi Tahu, 2017).

Customary birthing practices are collective and holistic, and they begin with the health of individuals before they contemplate conception. All steps of customary birthing practices are executed to obtain optimum wellbeing. It was innate to our tūpuna that it is easier to prevent than treat, therefore, they lay the platform of healthy cultural practices to achieve the desired outcome of healthy pēpi and healthy whānau. It made sense and it worked for Māori and, yet it was discarded at the turn of the 20th century with the passing of the Midwifery Act in 1904 and, to a lesser extent, the Tohunga Suppression Act in 1907. The latter being strongly driven by members of the Young Māori Party (AJHR, 1906, 1907; Buck, 1949; Donley, 1986, Mein-Smith, 1986; Stojanovic, 2008).

8.2 Section Two: The degenerative outcome of cultural suppression

Making sense of our world through mythology

Mythological narratives are repositories of moral encounters with embedded knowledge and messages used as a teaching tool for the audience they were shared with. Symbols entrenched in mythology generated another stratum of knowledge such that only those specialised in ancient wisdom, such as *tohunga*, would be able to comprehend their deeper meaning. Gonzales (2012) and Florescano (1997) referred to this inscribed symbolism in Mexican Indian creation mythology as encoded knowledge. Concepts were hidden in the Aztec codices produced on long-folded deerskin or planted fiber sheets. Numerous pictorial expressions and metaphors were positioned to protect knowledge from being lost, inaccurately told or falling into rival hands (Florescano, 1997; Gonzales, 2012).

Gonzales (2012) concurred that, like Māori mythology and Māori art symbols, Mexican Indian knowledge also revealed birthing images that articulated the sacred powers of birth, alongside the relationship between people and the natural world. These mythological images can also be illustrated in other mediums, such as rituals, rites and ceremonies, therefore validating myths as another repository of cultural knowledge and values. First Nations customary birthing practices preserve an affinity for equilibrium between mother and child, child and their ancestral connections, and child and their spiritual world (Boas, 2006; Bruyere, 2012). First Nations and Inuit people believe creation mythology held a critical function in defining their existence and lineage. Bruyere (2012) claimed that it is from creation mythology that people gather strength to uphold cultural knowledge.

Creation *pūrākau* assist the process of keeping Ngāi Tahu stories in our living memories. As a mnemonic tool, *pūrākau* or stories often describe a life cycle from the germination of a seed through to its death. The telling of Ngāi Tahu creation stories and incantations by Ngāi Tahu historians Matiaha Tiramōrehu and Teone Tikao proved that there were many ways to express a story. Many storytellers were influenced by their own teachings and their own beliefs. Collectively, the use of symbols as a

communication tool between groups, and from one generation to another; expressed their cultural foundation and understanding of life (Gonzales, 2012). However, colonisation has suppressed our creation narratives or placed them in the children's stories category rather than allowing them to be told as a philosophy of hauora, mauri ora and waiora (wellbeing). We assimilated not only our daily lives to the Western way, but our mindsets became conditioned in the norms, morals and ethics of the dominant culture (Kirby, 2007). Although, these creation pūrākau still need to be told to our tamariki, they also need to be brought to life as a philosophy to live by for our pakeke (adults) and kaumātua. The values and teaching in all creation pūrākau are enduring and relevant across the lifespan.

Ngāi Tahu customary birthing rituals

Rituals for childbirth started long before a child had been conceived. They began in the preparation phase of a hine (virgin girl) for her first act of copulation, throughout her hapūtanga (pregnancy) to nourish the development of the growing foetus, and post birth to cleanse the tapu of the parturition space (Barlow, 1991; Beattie, 1990). Another function of birth ritual was to infuse knowledge in the whānau, mother and baby, to protect the wellbeing of the child and to connect the child to their whakapapa, their greater creation narrative and to Te Ao Turoa (their physical world) (Makareti, 1938; Marsden, 1992, 2003). Gonzales (2012) referred to rituals as ceremonies that honoured the phenomenon of birth through a deep spiritual cleansing practice.

Karakia (invocations) are a central thread in Māori rituals, as they provide the spiritual oratory to aid the effectiveness of what was being applied, intended or required. Marsden (1992, 2003) warned that karakia needed to be recited word perfect in ritual ceremonies to avoid misfortune. The tohunga (expert) carried this level of expertise and mana, and therefore was given the task of conducting karakia. However, the loss of kaumātua (Māori elders) who were proficient in te reo Māori (Māori language), and who were confident and competent in providing appropriate kawa and karakia, is one of the contributing reasons for the decline in some kawa practices for Māori (Marsden, 1992, 2003).

Waiata convey the culture of people, deliver messages that inform understanding and give direction. Waiata are also sung to entertain, be humorous and are given as a koha to show gratitude or to honour a significant person (Ka'ai-Mahuta, 2010; Mead, 1969). Oriori (lullabies) are waiata sung to pēpi in utero, during and after birth. Oriori and other forms of waiata are performed by the labouring wāhine and/or those attending to her. Oriori create a platform from which to transmit tribal knowledge about creation, whakapapa, tribal warfare and relationships between people, iwi and realms. The ancient waiata sing the genealogy to the pēpi but also the whakapapa of the natural world. Often, the words reflect a form of mapping or signposting that aid the pēpi through labour, birth and beyond.

Raina Sciascia of Ngāi Tahu teaches oriori to wāhine in her mana karanga wānanga (traditional female calling custom workshop) and she agrees with Nunns and Marsden that vibrations are another transference medium for knowledge. She says the ihirangaranga (vibrations or sound waves) access old files encoded within the child's mind. Sciascia (2017) claims the sound of the oriori resonates within the child through the words and vibrations. Tikao shared an oriori with Herries Beattie in 1920 that was sung to comfort a pēpi. It reflects upon the mana of pregnancy and birth.

E tama hoki koe mahaku e whakaputa nei koi i tērā o te waru
 Oh son, return to me and bring forth this vitality in the sun for eight months
 Kei te putanga i tua, kai te putanga i whea, kai te Auatare
 Brought forth by you, brought forth in time
 Ia Te Moretu, Ia Te Moremau, Ia Te Moretaketake
 Of Te Moretu (the tree is planted), of Te Moremau (the roots are embedded)
 and of Te Moretaketake (the tree stands firm).
 Kihai i ea i a Te Māku ngā pou a Tāwhiti, ngā pou ā to tipuna ahua torikiriki
 Not emerging in the time of Te Māku (wet season), the posts of Tāwhiti, the
 posts of the ancestors appearing small.

Oriori can highlight the spiritual layers or realms and reference atua associated with cosmology. They can personify environmental elements that may indicate a phase of birth and install courage in the pēpi to come forth (Ka'ai-Mahuta, 2010; Mead, 1969; Orbell, 2004). An example given of this, is an extract from an exceptionally long oriori titled, *He oriori mō Tuteremoana*. It is believed that a version of this oriori was sung at the birth of Ngāi Tahu rangatira Tū Āhuriri.

I hara mau rā koe i te kūnenga mai o te tāngata
You have indeed come from the origin of mankind
I roto i te āhuru mowai
From the cosy haven emerged
Ka taka te wai o huaki-pōuri
The barrier of darkness ajar
Ko te whare hangahanga tēna a
The abode of the renowned
Tane nui a rangi
Tane of the heavens
(Tūhotoariki, 1907).

In the 1930s, it was not uncommon that Pākehā historians and academic writers became the experts from whom to seek reference and greater understanding of customary birthing practices while Māori sharing their knowledge were largely ignored. An example of this, is Elsdon Best's book, *Te Whare Kohanga* (The Nest House), on Māori customary birthing knowledge which was endorsed as a preferred book for nurses to read as guidance for working with Māori clients (Goodfellow, 1930).

This thesis sought karakia that were relevant to Ngāi Tahu whakapapa, then attempted to find the context in which they were applied. Finding the setting assisted with comprehending the words, names and places to give greater meaning to the content. Creation karakia similar to waiata had a rhythm or a template based on whakapapa. The whakapapa informed the content and the content informed those listening. Ultimately, Ngāi Tahu customary birthing rituals and practices are crucial components in the restoration of Ngāi Tahu wellbeing. Rediscovering knowledge pertaining to conception, labour and birth is a decolonising mechanism. It empowers not only Ngāi Tahu as a collective but also Ngāi Tahu wāhine as equal partners in the revitalisation of cultural practices. Tupuna Māori lived in synchronicity with the taiao (environment); this connection is vital to wellbeing. Customary birthing practices utilise natural resources and they connect Ngāi Tahu back to their philosophical foundation – to things that are so crucial to who they represent.

Can we hear what the art is saying?

The inclusion of Māori art in this study arose after discovering how challenging obtaining literature about customary birthing practices was proving. This forced me to consider other repositories of knowledge in the Māori world and I began an investigation of Māori art symbolism. Interviews with Māori artists specialising in whakairo and raranga confirmed a connection between the motifs embedded into the many forms of Māori art and cosmology.

Whakairo was our written language, it was one of the ways we wrote our stories, we had waiata which is oral but whakairo, tukutuku and kōwhaiwhai are our written language. Only certain people knew how to read it, like tohunga or rangatira. A carver would go to carve a wharehau and they would go to these people to get the whakapapa. They would have to interpret this kōrero into whakairo (York, Ngāi Tahu, Kaiwhakairo).

Older style whakairo demonstrated whakapapa, ancestors, death, and birth. Tokotoko (ceremonial walking sticks) depicted the genealogy of the person it was gifted to, often someone of note in the hapū and iwi. Sometimes small carved faces were recognised in pou whakairo, representing a baby being born. Imagery like this appeared less post colonisation and the influence of Christianity. Uninhibited referencing on the whakairo was often termed as grotesque by Christians (J. York, Ngāi Tahu, kaiwhakairo).

Other Māori taonga, such as, waka, hoe, whare whakairo, pātaka, taonga and weapons (to itemise a few) shared stories through symbolism and how they were fashioned.

It's the way a garment is constructed. If a garment is made for women who are bearing children, then the puka are placed to allow that baby bump to be covered. It is simple things like that. How the garment is constructed with what it is covered in. Whether it is lightweight and cool, or it may have extra covering on it to make it warm and protective (Ngarimu, Ngāi Tahu, Ngāti Mutunga, Kairaranga).

Some Māori whakairo were more explicitly concerning reproduction than others, for instance huataki or pare (door lintels) talked directly to the mana of wāhine, procreation and childbirth (Arcey, 1977; Barrow, 1969; Buck, 1949). Huataki illustrated the past and the present; the divide between the outside world, often associated with the atua Tūmataunga (god of war), and the inside space of the whare as the atua Rongamātane (god of agriculture and more peaceful activities) (Buck, 1949). The placement of the huataki above the doorways of wharenui reflected the respect inferred from the reproductive imagery. Frith (1925) stressed the connection between huataki and cosmological referencing was expressed in the continuity and relief of the patterning.

What can perhaps be said, is that the frequency and high regard of creation and procreation symbolism was a necessity to keep this knowledge and the people from becoming extinct (Allingham, Personal Communication, March, 2016; Flintoff, 2004; Frith, 1929; Simmons, 2007; Tapsell, 1998; J. York, Ngāi Tahu, kaiwhakairo). Creation symbolism affirmed the importance of traditional knowledge remaining as a philosophy ingrained into a culture's genetics. The imagery in huataki provide perhaps the most clarity of all the whakairo in their portrayal of reproduction, and how much they were valued by iwi through their placement on prestigious pā buildings (Allingham, Personal Communication, March 2016; Flintoff, 2004; Frith, 1929; Simmons, 2007; Tapsell, 1998). Crey (2020) shared that the Indigenous future is always situated in the present. Indigenous people think like their forebears, about how their actions will impact on those yet to be born. What am I doing today that will benefit those yet to arrive?

8.3 Section Three: Mana wāhine atua mana reo wāhine

Reclaiming our tūrangawaewae in birth

Wāhine Māori have been disempowered through colonisation, assimilation and the hospitalisation of birth. Layers of oppression spread over generations have consumed the power wāhine Māori once confidently wielded. One of the brutal blows to wāhine Māori, was their inability to birth at home, and the loss of their Māori lay midwives (Donley, 1986; Mein-Smith, 1986; Papps & Olsen, 1997; Simmonds, 2014). The physical and symbolic act of birthing was aligned with the role of Papatūānuku (earth mother) as the universal mother, the generator, and nurturer of life.

Women are the first environment. In pregnancy our bodies sustain life. At the breast of women, the generations are nourished. In this way, we as women are Earth (Cook, 2003, n.p)

The whare tāngata or womb of a wāhine is considered across many Indigenous cultures as not only the carrier of life but a receptacle of cultural history and identity. The lay midwives, both wāhine and tane, were kaitiaki (guardians) of the whare tāngata, the pēpi, the wāhine, the whānau, and mātauranga Māori associated with childbirth. Colonial legislation and valuing Western science more than Indigenous knowledge led to the decline in numbers of Māori lay midwives. This added to a prognosis of persistent poor health and social status for wāhine Māori over the generations. Murphy (2019) highlighted the sullied impression that may have been imprinted on the minds and hearts of many Māori ancestresses and carried through the whakapapa:

The erasure of Māori and Native ritual histories that venerate Native women's reproductive bodies as a symbol of the regeneration of tribal societies, and their replacement with sweeping statements of a debased womanhood, have been internalized by many Native girls and women today (p. 277).

That wāhine Māori must have felt dispirited and devalued by most settler men and women disapproving of their natural practices is an understatement and stirs up such a deep sense of injustice. Simmonds (2011) argued that mana wāhine is a space where

wāhine Māori are self-determining, defining and telling their stories of their lives and experiences. Historically, males have dominated the reciting of Māori creation narratives. They often favoured the male characters and gave insubstantial descriptions or details to the female deities or stories beyond what nurtured the male lead. The rejuvenating of birthing rituals and practices will highlight the role of Papatūānuku, Hine-hauone, Hine-pu-nui-o-toka, Hine-aroraki, Hine-aroaro-pari, Hine-roriki, Hine-rotia, Hine-tītama, Hine-akeake, Hine-a-tauira Hine-nui-te-pō, Hine-te-iwaiwa, Tahu-kumea, Tahu-whakairo, and the many female deities that played a substantial part in our Māori cosmology. Emphasis needs to be placed on these female entities as role models for our young wāhine today, for they are all inspiring and carry values that are eternal.

We need more Ngāi Tahu wāhine storytellers sharing these accounts of our wāhine atua to reinvigorate the uha (female essence) within our creation mythology (Bruyere, 2012; Gonzales, 2015). Simmonds captured this sentiment when she wrote:

Māori women have been involved with the struggle to retrain and regain their sense of self from the very moment colonial discourses and hierarchies reached our shores (2011, p.12).



Fig 16. Presley Ziogas, Jasmin Canuel, Rosie Tapsell and Imogen Tapara performing in the premiere of Onepū in October 2018 “Wind Goddesses”. Photographer Julie Zhu. Choreographer Louise Potiki-Bryant.

Ngāi Tahu choreographer and video artist Louise Potiki-Bryant choreographed a dance performance, called *Onepū*. It was based on a story that Teone Tikao shared with historian Beattie in the early 1920s. The performance highlighted six wāhine deities who symbolised the different directions of the winds. Ngāi Tahu taonga pūoro artist and kaiwaiata Ariana Tikao (Ngāi Tahu), and great-mokopuna to Teone Tikao, performed in one of the seasons. This was a rich collaboration of Ngāi Tahu wāhine honouring wāhine atua, giving life to ancient Ngāi Tahu waiata and displaying these stories on stages around the country.



Fig 17. Imogen Tapara, Rosie Tapsell, Jasmin Canuel and Presley Ziogas “Atua Wāhine”. Onepū Performance in the Atamira Dance Company season of Kōtahi, October 2018. Photographer Julie Zhu and Choreographer Louise Potiki-Bryant.

In 2015, Ngāi Tahu also facilitated a long-term exhibition that celebrated the lives of Ngāi Tahu wāhine from the perspective of their descendants. The curator, Migoto Eria, reflected that the exhibition honoured not only the 50 wāhine in the exhibition but all Ngāi Tahu tūpuna wāhine who protected Ngāi Tahu knowledge and offered vital guidance to their hapū and iwi (2015, n.p). Therefore, the stage, exhibitions and media are just some of the platforms to successfully display the lives and pūrākau of wāhine

Ngāi Tahu. Celebrating wāhine Ngāi Tahu in creation and everyday life will contribute towards liberating their individual and collective uha (female energy).

In 1993, Ripeka Evans, Donna Awatere, Paparangi Reid, the late Dame Mira Szaszy, and other representatives of the Māori Women's Welfare League filed a claim that is now known as the Mana Wāhine claim at the Waitangi Tribunal. The claim said that the actions and policies of the Crown had "systemically discriminated" against wāhine Māori (Hayden, 1918, n.p). In December 2018, the Waitangi Tribunal confirmed that breaches of the Treaty of Waitangi had been made concerning wāhine Māori (Dunlop, 2019). The claimants identified structural and institutional barriers that restricted the spiritual, economic and social wellbeing of wāhine Māori. This has been given further support with the announcement by the Minister of Women, Julie Anne Genter, that 6.2 million dollars will be given to a specialist group to research and develop an eventual government response to this claim and Waitangi Tribunal instigated inquiry, alongside the government agency Te Puni Kokiri (Dunlop, 2019).

Hospitalisation of birth another tool of assimilation

Bruyere (2012) surmises that the "medical model has served to dehumanize the sacred birthing experience" by minimising the value in its retention (p.42). The hospitalisation of childbirth has led to a natural process becoming layered with interventions, such as caesarians, epidurals, inductions and episiotomies. The New Zealand government established the Health Departments in 1900 and one of the initial focus points of action was infant and maternal mortality. It was strongly believed that improved hygiene standards and assimilating to Pākehā lifestyles would resolve poor health issues for Māori (Banks, 2000; Donley, 1986; Exton, 2008; Stojanovic, 2010). These went beyond the inability of Indigenous women to birth in their homes and more severely to the denial of cultural knowledge and identity. The 1904 Midwives Act was passed that made it illegal to practice as a midwife unless you had formal midwifery training through the state-owned hospitals, later called the St Helen Hospitals (Gulliland & Pairman, 2010; Stojanovic, 2010). Bruyere (2012) argued that the cultural norms for Indigenous women were significantly compromised with the advancement of scientific

methodologies. In the 1930s, 87 percent of all New Zealand births took place in hospital. Māori made up 16.8 percent of births registered in hospitals. The passing of the Social Security Act in 1938 made maternity services free and lengthened the hospital stay to a two-week period. Māori birthing in hospitals rose and 90 percent of Māori births took place in hospital by 1962.

In the 1970s, Canada centralised its healthcare instead of improving or even providing health and maternal services in the more remote areas. It was decided that these communities would be transferred to the larger cities or towns for their health needs (Klein et al., 2002). When the Canadian government adopted the medicare health care programme in 1972, funding was only given to physicians to provide maternity care, effectively forcing midwives to retire, and in some Canadian provinces' midwifery became illegal (Benoit et al., 2012). Some maternity services were not included in the provincial healthcare system and were not covered by provincial insurance. This meant women had to pay their midwives and it soon became a service only available to those who could afford it. Choices became obsolete and gradually many Indigenous communities had to accept that going to hospital under the care of medical practitioners was their only option (Cameron, 2005; Turnbull et al., 1990). However, Indigenous midwives at the 2019 Indigenous Midwifery Summit in Ontario raised the fact that Indigenous peoples' understanding of maternity or health risks are not the same as 'risks according to the biomedical model. They believe it is a powerful divide between cultures and highlights dominance by one culture over another.

The concept of risk is used to remove Indigenous people from communities, which extends to the medicalization of birth and the forced removal of women to leave their community (Association of Ontario Midwives, 2019, n.p).

Birthing in hospital has become normal and having baby at home is perceived to a certain extent still as "alternative". Rongoā Māori (Māori traditional medicines and treatments) have also been termed alternative and inferior to Western treatments. This is despite the formation of Te Kāhui Rongoā Trust in 2011, a national rongoā governance body that came into fruition to protect and promote rongoā Māori to ensure the rongoā is of high quality, is safe and the rongoā services set professional standards (Turia, 2014). Home births contribute to three percent of the overall birth statistics in New Zealand and this figure is predominantly made up of Māori and Pākehā. Birthing

at home allows more opportunity to invite and support customary birthing practices and rituals inclusive of rongoā. More support may be needed to assist midwives to recognise that home birth is a site for reinvigorating traditional knowledge.

Fredette (2017), from Northern Manitoba in the Norway House Cree Nation, said that the joy of birth in the First Nations is rarely celebrated, but the honouring of someone passing is. Kanahus Manuel of the Neskonlith Indian Band of Secwepemc Nation in British Columbia stressed that birth in itself is an act of decolonisation and resistance. The return of customary birthing rituals to First Nations communities contributes to reducing the physical and spiritual damage of health inequalities suffered by the Indigenous people of Canada and is a proactive movement towards healing some of the historical trauma still felt by these communities (Allan & Smylie, 2015; Duong, 2018).

Recognising the impact of entrenchment in the birthing space

This research aligns with previous doctoral research conducted by Naomi Simmonds in 2014 that examined how colonialisation and patriarchal dominance became implanted in the childbirth arena, and how this impacted wāhine Māori. Murphy's doctoral research in 2019 examined the way Hawai'ian and Native American women actuate female ceremonies and evoke the feminine deities (Murphy, 2019). This body of work contained many elements that correspond to papers and articles encompassing themes of tino rangatiratanga, kaupapa Māori, mana wāhine, mātauranga wāhine, creation pūrākau and Māori midwifery (Jenkins & Pihama, 2001; Lee, 2005; Mahuika, 2008; Smith, 1999).

This thesis touched on themes similar to those mentioned above but with greater attention given specifically to Ngāi Tahu birthing knowledge and practices. This included a contextual sweep that commenced with the creation of the universe through to promoting a Ngāi Tahu kaupapa Māori primary birthing unit. There is a great deal more to be done in this field of mātauranga. Those who have delved into the Māori

birthing area in the recent past are immensely respectful and supportive of research endeavours for the collective empowerment of wāhine Māori.

8.4 Section Four: Colonial legacies and the challenge to Ngāi Tahu birthing knowledge

Maranga mai Ngāi Tahu e (Rise up Ngāi Tahu)

The evolution of Ngāi Tahu is a story of grit and tenacity. From their feuding arrival into the South Island and early trading economy with other iwi and early settlers, Ngāi Tahu's future began to look promising in the mid-1820s. This was until the appearance of Ngāti Toa and their leader, Te Rauparaha, who brought the first wave of suffering and the Tiriti o Waitangi brought the second. The bloody feuds in Kaiapoi and around the Banks Peninsula devastated Ngāi Tahu in Canterbury. The quick inflation of European settlers into New Zealand rapidly turned the population figures around and Ngāi Tahu were outnumbered by far. In the 1830s, with an influx of over 500,000 settlers to New Zealand between 1820 and 1890, the scene was set for a dramatic change (O'Regan, 1991; Tau, 1997, 2013; Waitangi Tribunal, 1991).

Early settler governments did not enforce accountability over what was promised in the Tiriti o Waitangi and promises were continually broken. Ngāi Tahu lost their access to mahinga kai (food sources) and had minimal political autonomy. The land sales were excessive and dubious on all accounts, but this did not stop the missionaries, the teachers and the politicians all promising with one hand while firmly swiping the carpet away with the other. Reid et al. (2017) described this rise of material poverty and disease as core components of Māori historical trauma from a colonising environment. The only tool Ngāi Tahu had left was the mana of their whakapapa and their absolute belief in truth and justice. They produced petitions and went to the government again and again over generations, insisting that the government address the Tiriti o Waitangi breaches. Instead of reprieve, Ngāi Tahu experienced more Royal Commissions of Enquiry. Very little seemed to be achieved from Commissioner visits, they came, they heard, and they wrote their recommendations to the government (which were very similar to each previous report) but to no avail. Iwi representatives who fiercely advocated for righting the injustices of Ngāi Tahu passed away with no success to their pleas. It took 150 years of appeal to the Crown to rectify the blatant Tiriti o Waitangi blunders.

Nine Tall Trees

Over a 20-year period between 1844 to 1864 and ten substantial land sales, Ngāi Tahu became effectively landless. The Ngāi Tahu claim, called Te Kerēme, was presented to the Waitangi Tribunal in 1986. A total of 73 grievances were described under nine headings: eight pertaining to land sales and the ninth concerning the loss of mahinga kai. These nine headings were known as the Nine Tall Trees of Ngāi Tahu. The Waitangi Tribunal response to Ngāi Tahu came in 1991 in their report, which conceded that Ngāi Tahu had experienced grave injustices. The following statement appeared at the beginning of their report summary:

The narrative that follows will not lie comfortably on the conscience of this nation, just as the outstanding grievances of Ngāi Tahu have for so long troubled that tribe and compelled them time and again to seek justice. The noble principle of justice, and close companion of honour, very much the subject to question as this inquiry proceeds (1991, p. xiii).

The Waitangi Tribunal report led to The Settlement Deed in 1997, with a later apology from the Crown. It was a bitter-sweet victory for Ngāi Tahu that provided the opportunity to begin again. However, the Settlement Deed would never take away the historical trauma that had been embedded into the whakapapa of Ngāi Tahu. This lengthy period fighting the Crown was consuming and costly in terms of lost customary practices such as those associated with childbirth.

Historical trauma

Reid et al. (2017) used the term “colonising environment” to describe the trauma and impact on the psychosocial wellbeing of Ngāi Tahu after their ongoing exposure to the settler communities. The trauma is not an isolated event but experienced through numerous and compounding exposures to settlers and the Tiriti o Waitangi breaches. It was the colonising environment that severely contributed to the loss of customary

birthing practices and rituals, as Ngāi Tahu were coerced to take on Western birthing practices that took away the need to incorporate rituals associated with these cultural practices. Ngāi Tahu have already begun to counteract the colonising environment by investing in their cultural renaissance. They have run regional and national hui to gather Ngāi Tahu together; they have engaged more members to take part in hapū and iwi activities and to become involved with their Marae for members to be supported to learn about their whakapapa, te reo Māori and their whenua to feel more strongly associated to their Ngāi Tahu identity. This contributes greatly to Ngāi Tahu members being more open to receive and accept the value of cultural knowledge and to enhance their physical and emotional wellbeing (Reid et al., 2017).

What can be gathered from understanding the historical referencing, is the ‘why’ context that played heavily on the decline of customary birthing traditions. The depth and length of colonial impact has been a strong reason why Ngāi Tahu left their own practices and rituals and transitioned to those of the Western society. Some of the customary practices would have naturally evolved as cultures and circumstances do over time (Gloyne & Mātāmua, 2020). Therefore, tūpuna Ngāi Tahu may have welcomed certain elements of Western practices but the evolution of culture starts with something momentous occurring; for instance, the influenza pandemic in 1918 and the Covid-19 pandemic in 2020, which then leads to cultural reflection and potentially a tikanga change (Matāmua, 2020, Yellowbird, 2020). Ngāi Tahu practices and rituals, such as tangihanga, are then addressed nationally, and across iwi and hapū reflection occurs on how practices and rituals have to change to address the current phenomenon. When cultural change is forced through laws, there is no room for a culture to have a voice in their own evolution, their adjustments of practices and rituals. Ngāi Tahu have remained steadfast and it is their grit that will see the return of traditional practices, such as customary birthing practices (Moewaka-Barnes & McCreanor, 2019; Reid et al., 2014, 2017).

8.5 Section Five: Revitalising Ngāi Tahu Birthing Practices

Ngāi Tahu Aoraki Matatū e!
(Be proud Ngāi Tahu like our prestigious mountain Aoraki)

In 2020, there are approximately 67,000 Ngāi Tahu members. Ngāi Tahu make up just over one percent of the total New Zealand population, and just over eight percent of the total Māori population. The population of Ngāi Tahu, alongside other iwi, will rise. This is due to infant mortality rates declining and a greater compliance with the immunisation programme, some improvements in socio-economic status, and elderly Māori living longer lives (Cowan, 2015). The exponential growth area for Ngāi Tahu is with the youth demographics who will eventually become parents. Yet, while a Ngāi Tahu population boom is expected, the number of midwives in the workforce is dwindling, meaning that an even smaller number of Māori midwives will be available to meet the upcoming whānau demand (Te Rūnanga o Ngāi Tahu, 2018; Statistics New Zealand, 2018; R. Chisolm, Ngāti Porou, Māori midwife).

Prioritising mātauranga Māori in the midwifery curriculum

The New Zealand College of Midwifery argues that they do endorse Māori knowledge in the midwifery degree curriculum. However, to what extent are they requiring midwifery programmes to provide for Māori and are these offerings enough to grow and sustain more Māori midwifery students?

Both midwifery lecturers and midwifery students in the research cohort described their programmes as packed with content due to changing the degree from four years to three. More Māori customary birthing knowledge is needed in the midwifery degree curriculum and practicum. Mātauranga Māori is a taonga under Article II of the Tiriti o Waitangi and should not be consigned as optional or additional, like a footnote but be included within the knowledge framework from the beginning and prioritised as essential knowledge. Some midwifery students were resigned to the fact that midwifery

training would have little Māori content. Given the volume of learning material they already had to work through, more specific Māori customary birthing rituals would have to be completed post their midwifery degree (T. Stone, Ngāi Tahu, Māori midwifery student; D. Gibb, Ngāi Tahu, Māori midwifery student). However, it can also be ascertained that Māori knowledge appears not to be prioritised and may speak to the professional midwife as a product of colonialism. The history of the lay Ngāi Tahu midwife is one of *karakia*, *rongoā*, *waiata*, and sacred birthing spaces, spiritually and physically. The European midwife, in contrast, was subsumed into hospitals where a biomedical culture presided.

The lure of Ngāi Tahu midwives

Māori midwives of the past were known and respected as knowledge carriers. They learned the *tikanga* (customs), the *pūkenga* (skills), the *pūrākau* (stories), and *whakapapa* of many *whānau* in their *rohe*. This is a common phenomenon in many Indigenous communities. The Indigenous midwives alongside other tribal specialists, for instance, *tohunga* for Māori, were frequently called upon to uphold the *mana* and *mātauranga* of their *hapū* and *iwi*. Within the mind and hearts of these selfless nurturers, they held the creation narratives and seemed to work smoothly between the spiritual and physical realm. Today, we have very few Māori midwives that feel confident and competent to fulfil this role. This is understandable, given the suppression of knowledge and conditioning away from ritualistic practices. Among those interviewed for this research, there was an overwhelming interest in relearning these customary birthing practices and bringing them into their current practice with *whānau*. This comes with a few disclaimers and hesitancies that have been mentioned before in terms of Māori midwives needing professional backup during their midwifery registration to enable them to offer customary birthing practices within the realms of their midwifery registration (Rama, 2011; J. Te Huia, Ngāti Kahungunu, Māori midwife).

It is imperative that we provide incentives for more Ngāi Tahu midwives to re-enter the midwifery workforce with good financial rewards, cultural support and ongoing Ngāi

Tahu professional development at the same time as a strong and sustained recruitment of Ngāi Tahu into midwifery training.

Greater recruitment and retention of Ngāi Tahu midwifery students, Māori midwives and tutors.

We need a greater number of Ngāi Tahu enrolments through to completion of their midwifery degrees. Māori have the highest attrition rate in midwifery degrees and often leave after their first year. Māori midwives are also too few and often stretched in their work capacity such that burnout and early retirement has become inevitable. More targeted promotion of midwifery through a Ngāi Tahu and Māori lens, such as the documentary series, *My Māori Midwife*, which screened on Māori Television in 2019, are necessary. Active recruitment by Māori in prominent Māori communities, at hui Māori and in Māori media will eventuate in a higher proportion of Māori in the midwifery workforce, though structural barriers remain.

It would be of benefit to create financed opportunities for Māori to study midwifery and internships for midwives to gain teaching skills that assist their transition to tutoring. More Māori tutors are needed to deliver Māori content and provide support to Māori students. Similar to the midwifery workforce, having one Māori tutor heightens the risk of the tutor feeling marginalised, therefore the recommendation would be either networking the Māori tutor to other tutors on the education campus or employ more than one Māori tutor.

Provision of professional development for midwifery educators and midwives is also necessary to aid their understanding of the importance of being inclusive of traditional Māori birthing practices in midwifery practice. This may eliminate fears and mistrust harboured by those making the decisions around curriculum content. Facilitating rolling wānanga for midwives to attend that teach customary birthing practices and rituals, with priority initially given to Māori midwives, may grow the overall support for these practices and awareness of creation narratives.

Self-determining our maternity future

It was raised at a national Ngā Maia Māori Midwives o Aotearoa conference in 2016, that Māori midwives could address the call of many whānau wanting more support post-natally over a longer period. Ngāi Tahu could, with adequate and high trust government funding, address this issue and provide post-natal support in collaboration with other services to ensure our whānau receive access to care.

There is currently no specific strategy within Te Rautaki Hauora Ngāi Tahu that envelops customary Ngāi Tahu birthing knowledge and practices. There is, however, scope within key policies and with other significant Ngāi Tahu strategies to foster the reclamation and revitalisation of Ngāi Tahu birthing practices. The reintroduction of Ngāi Tahu birthing knowledge and practices is likely to entice many whānau Ngāi Tahu to want this option in their maternity experience. I believe customary birthing knowledge and practices will be included in the next Te Rautaki Hauora beyond 2025.

Ngāi Tahu 2025 is the Ngāi Tahu tribal strategy with their goals and aspirations over a 25-year period. Vision 2025 was produced by Te Rūnanga o Ngāi Tahu in 2000 and concentrates on nine key areas for the tribe, inclusive of: the natural environment, tribal communications, influence, papatipu rūnanga development, education, governance, and investment. Two other areas of interest to this thesis are culture and identity, and social development. Under social development, Ngāi Tahu target whānau wellbeing by providing resources that will assist identified whānau needs and ambitions. It is also stated that Ngāi Tahu will support whānau to take part in hapū and iwi initiatives that improve their emotional, mental, physical and spiritual health. Ngāi Tahu would like to remove barriers for whānau Ngāi Tahu so that they can reach their optimum potential and in turn encourage their whānau whānui to do the same.

At the next annual review of the Vision 2025, Kotahi Mano Kaika and Te Rautaki Hauora strategies, it would be advantageous to lodge a submission requesting Ngāi Tahu consider their role in the revitalisation of Ngāi Tahu creation narratives, customary birthing knowledge, rituals, and practices woven throughout all major strategies for greater awareness and preservation.

Ngāi Tahu whānau and hapū were deeply affected by land alienation through settler legal systems and assimilation. The key factor in terms of this doctoral research, is what was lost with the land and the passing of generations was integral cultural knowledge, such as customary birthing knowledge and practices that were once highly valued for providing cultural strength. Bringing back customary birthing practices will contribute towards the acknowledgement and respect for Ngāi Tahutanga (identity), mātauranga (knowledge) and whanonga pono (values).

The Waitangi Tribunal released their Stage One findings from the *Hauora Report of the Health Services and Outcomes Kaupapa Inquiry* in 2019. The report found that the Crown did not work effectively with Māori to develop a primary health care system. The Tribunal wrote that the Crown failed to consult with or provide appropriate support and funding to Māori to hauora programmes and services. This had a detrimental effect on Māori being enabled to sustain good health. The Crown has till January 2020 to respond to the Tribunal's report and recommendations. Ngāi Tahu are currently taking this report into consideration as they work towards achieving the five key strategies of their Hauora Strategy, Te Rautaki Hauora 2017-2025, on behalf of the members of Te Rūnanga o Ngāi Tahu. Three of these strategies directly relate to the above findings from this thesis, which are:

Advancing Tino Rangatiratanga (self-determination) within the whānau and hapū that will eventuate in greater hauora outcomes. A recommendation would be the development of a Ngāi Tahu Kaupapa Māori Primary Birthing Unit. This is about installing Ngāi Tahu values and rituals into practice and housing these within a building that welcomes whānau Ngāi Tahu. (greater detail discussed below under title Mo ngā uri a muri ake nei – A Kaupapa Ngāi Tahu Primary Birthing Unit).

The second key Ngāi Tahu hauora strategy is *Improving Access to Hauora Service Provision*; this relates to alignment to a strength-based model of care that is driven by the whānau and is culturally appropriate. Te Rūnanga o Ngāi Tahu will also partner with health services and work alongside them to improve their delivery of care and access for Ngāi Tahu whānau. The intent would be to actively encourage Ngāi Tahu to engage with health and social services to enhance their quality of life while retaining their Ngāi Tahu identity.

Workforce Development is the third strategy out of the five key strategies that I believe directly relate to this doctoral research. Ngāi Tahu stressed the importance of being leaders in setting health standards of care for whānau Ngāi Tahu. This also included increasing the numbers of Ngāi Tahu entering hauora professions and retaining their cultural integrity throughout their learning journey. Māori midwives in this doctoral research and in my master's degree project said the midwifery standards did not always support them in their delivery of Māori practices and rituals and, therefore, deterred them from actually employing customary birthing practices in their professional care. Ngāi Tahu aiming to have a say in standards of care may create room for customary practices to be included and accepted by midwifery regulators. This will ensure Māori midwives remain safe within their practice and their midwifery registration.

Empowering Māori Midwives

Ngāi Tahu midwives are already advocates in their roles and workplaces and many have indicated that they are eager to incorporate customary Māori birthing practices in their professional practice. They see this happening alongside support from their kaumātua (elders) and access to a network of local Māori midwives (R. Chisolm, Ngāti Porou, Māori midwife; D. Gibbs, Ngāi Tahu, Māori midwifery student; T. Stone, Ngāi Tahu, Māori midwifery student; J. Te Huia, Ngāti Kahungunu, Māori midwife).

Some Māori midwives are less confident incorporating Māori customary birthing practices until they master this body of knowledge. They would also like to have assurance from the New Zealand Midwifery Council that customary birthing practices will be included in the scope of midwifery practice (R. Chisolm, Ngāti Porou, Māori midwife; Rama, 2011). Māori midwives who are assisting whānau with customary birthing practices can feel caught between their professional competencies and the scope of practice of their midwifery registration and their loyalty to mātauranga Māori. This can be conflicting and unsafe on a cultural and professional level. More needs to be done to address this conundrum for Māori midwives who are, or would like to incorporate more Māori birthing practices into their professional practice.

8.6 Section Six: E tipu E rea – Scaffolding Solutions

The following kōrero address areas of challenge and some potential solutions forward. This section concludes with an offering through the wisdom and experience of the First Nations and Inuit peoples who have already trodden this pathway of commencing their Indigenous-led maternity services.

Sustenance for Kaupapa Māori Antenatal programmes

There are still many Indigenous women who do not use their full entitlement to health services throughout their pregnancy and commonly believe they only need to use a service should a complication arise (Freyermuth, Villabobos & De la Tore, 2006; Servan et al., 2015). Māori women attend antenatal classes considerably less than European and Asian women (Health Services Consumer Research, 2008). This could be related to perceived risk varying between cultures. What one culture terms as risky is perhaps not how another would see it and vice versa. However, the cry from the health professionals both abroad and here in New Zealand is that complications can be missed or discovered too late with potentially fatal implications for both mother and child. Therefore, the general preference is for Indigenous women to seek early intervention by engaging with a Lead Maternity Carer earlier in their pregnancy. Māori midwives and non-Māori midwives involved with Kaupapa Māori antenatal programmes concur that antenatal programmes with a strong cultural component have a greater lure of hapū wāhine Māori and their whānau who commit to the completion of the programme (Freyermuth, Villabobos & De la Tore, 2006; Kelly, 2019; Servan et al., 2015).

More sustained and consistent government health funding is required for kaupapa Māori antenatal programmes to take them from the pilot phase to an ongoing community service. The First Nations and Inuit people similarly struggle to obtain government funding for Indigenous midwifery as the funding is often time constrained and unrealistic to achieve the desired outcomes in the funder-driven timeline. Approximately 13 midwifery practices developed for the Indigenous community,

including the Rankin Inlet Birthing Centre in Nunavut, The Six Nations Maternal and Child Health Centre in Ontario, and the Seventh Generation Midwives Maternity in Toronto, share this same concern. The lack of extensive funding made it challenging for these Indigenous collectives initially and perhaps to an extent today. Sustaining qualified Indigenous and non-Indigenous midwives and other maternity health professionals is another key issue. To be supported by the Indigenous communities whom they have been established to care for is also a surprising obstacle. More funding should be allocated for the completion of a health education and promotion package (Association of Ontario Midwives, 2019; Benoit, 2001).

Māori hauora providers need to be able to sustain antenatal programmes beyond short-term contracts. This culture of contractualism is recognised to foster high levels of staff turnover and undermines community trust. Achieving financial continuity will sustain Māori practitioners and keep the interest of Māori community maternity services on a long-term basis. Funders need to apply a high trust model to proven whānau-centred hauora services that provide a kaupapa Māori antenatal programme to ensure these programmes will be given support and space to develop and better meet the needs to whānau Māori in maternity.

To foster greater cultural provision of maternity care will require more resources and professional support within Māori services. Gathering local kairongoā (Ngāi Tahu rongoā specialists) who produce rongoā Māori for cleansing rituals and maternity care is essential. Other resources are needed too, such as waiata compilations that include oriori and tauparapara or providing iwi funding to produce compilations specific to hapū. Alongside these developments, the enlisting of other skilled artisans, such as kairaranga (weavers) to produce waha kura (sleeping baskets), muka whītau (cordage to tie the umbilical cord) and whāriki whānau mai (birth mats) is also essential. The kaiwhakairo pounamu (pounamu carvers) could be approached to carve stylised but functional maripi (knives) to cut umbilical cords and our kaikōrero (speakers) to learn specific karakia associated with tohi and pure rituals so these cleansing and protective rituals can be made more available to Ngāi Tahu whānau post birth. Rebuilding Ngāi Tahu rituals is a task for the wider iwi.

Mo ngā uri a muri ake nei (for the descendants to come) –
A Kaupapa Ngāi Tahu Primary Birthing Unit

The Canterbury Midwifery Rōpū began to investigate the feasibility of a Kaupapa Māori Primary Birthing Unit following the closure of the Burwood Birthing Centre in 2016. Their original plan was to offer a tender to the Canterbury District Health Board (CDHB) to be included in the planning of the Christchurch maternity service redevelopment. The Canterbury Midwifery Rōpū believed their tender met the Ministry of Health's desired outcomes for Māori in the health strategy, *He Korowai Oranga* (2014); with commitment to working towards healthy futures for Māori, healthy whānau, healthy environment, healthy individuals and a strong emphasis on supporting mātauranga Māori in the development of health services for Māori (MOH, 2019). However, running with a great idea whilst working full-time in midwifery and juggling their domestic responsibilities soon weighed heavily upon this rōpū. The reality of this task became reliant on the midwifery rōpū staying active, obtaining a substantial amount of funding to pay for feasibility research, and then more time and energy to develop a business proposal for the CDHB in the hope that the CDHB would accept their tender. Great vision and eager hearts are not always sustainable when your workforce is understaffed and overworked (R. Chisolm, Ngāti Porou, Māori midwife).

It would be of interest to Te Rūnanga o Ngāi Tahu to investigate the establishment of a Ngāi Tahu primary birthing unit. This would function as a Ngāi Tahu hub to foster Māori midwives in their professional careers and be an āhuru mōwai (shelter) for whānau Māori to have their pēpi in a kaupapa Māori setting with professional staff. This needs to be a Ngāi Tahu-led initiative to ensure our pūrākau and tikanga are woven into the fabrication of the establishment and are not simply an additional service to a mainstream maternity division.

A Kaupapa Ngāi Tahu Māori Primary Birthing Unit could also house a Ngāi Tahu kaupapa Māori antenatal programme. This would provide another avenue for teaching creation stories and whānau ora with the objective that whānau Māori will engage in antenatal services earlier and commit for the duration of the programme.

Inclusion of Ngāi Tahu customary birthing practices and rituals in primary and tertiary health modules, taught in a wānanga capacity

The wives of Ranginui previous to Papatūānuku, including Pokoharuatēpō and Hinemoana, wife of Kiwa – another guardian of the moana (sea), are examples of wāhine atua that need to be highlighted in creation stories told at kōhungahunga (early childhood centres), kura (primary schools) and wharekura (high schools) in the Ngāi Tahu takiwā. The work of Te Rūnanga o Ngāi Tahu's Kotahi Mano Kaika is an exemplar of how Ngāi Tahu are providing for their members with an active promotion of Ngāi Tahu pūrākau and mātauranga in resources and reo wānanga. This needs to be expanded and included into all education providers in the Ngāi Tahu takiwā (tribal area) by reaching out to the Ngāi Tahu whānui (and the extended whānau of Ngāi Tahu) to come and read these resources to grow the awareness of pūrākau Ngāi Tahu pertaining to creation and te reo Ngāi Tahu.

Sexuality programmes exist in all our schools and are being run with varying success. Having a Ngāi Tahu reproduction wānanga inclusive of creation narratives, Ngāi Tahu creation deities, personal body preparation, relationship preparation, awareness of karakia for fertility and pēpi, customary practices and rituals pertaining to pregnancy and birth would capture a wider collective of Māori.

We need to encourage all schools to activate their sexuality programme, as guided by the National Education Guidelines and the Sexuality Guidelines. Traditional Māori birthing practices need to be taught within these sexuality education programmes in intermediate and high schools. With three generations now having birthed in hospital, there are too few role models available with lived experience to advocate for traditional birthing practices from a place of knowing. This knowledge now needs to rest upon the shoulders and hearts of our rangatahi. They will carry this forward to the following generations.

In order to do so, we need to educate our rangatahi about traditional birthing practices and assist them to make or access rauemi (resources) poignant to this kaupapa (topic). This can, and eventually will, happen on the marae and at home but until this knowledge transmission takes hold of our rangatahi today, feeding this information out in many

forms to Ngāi Tahu rangatahi requires the assistance of our leading places of tuition, our Kura Kaupapa Māori and our mainstream schools.

Most schools currently comply with the National Education Guidelines 2004 (NEGs) to support learning arenas. NEGs nine and ten relate specifically to incorporating more Māori education initiatives that align with the Treaty of Waitangi to improve Māori student outcomes. NEG 10 says education needs to have respect for the ethnic and cultural diversity in New Zealand and also acknowledges the unique place of Māori within New Zealand (MOE, 1993). The New Zealand Curriculum (2007) places sexuality education most prominently in the health and physical education learning arenas and sexuality education is one of their seven key areas of learning.

The Ministry of Education (MOE) encourages sexuality to be taught within a holistic framework and highlights Mason Durie's Te Tapa Whā Hauora model (1994) as one example of a hauora Māori framework that can be used to teach sexuality. This hauora model addresses the physical, social, psychological and spiritual aspects of sexuality. The MOE also encourages schools to consider other Māori values and knowledge around sexuality, such as ira tāngata "the physical and spiritual endowment of children and the importance of nurturing both in their education" (MOE, 2015, n.p). Notions of whakapapa, creation stories and specific deities associated with creation, such as Hineahuaone and Hinetītama can also be included. The MOE also encourages teachers to utilise waiata (song), pūrākau and also whakataukī in their teaching of sexuality to Māori students. Approaching sexuality education with a Māori focus for Māori students, inclusive of their whānau and community, is believed to be more "effective and empowering" learning (MOE, 2015, n.p).

Māori students thrive in their school environment being themselves and being acknowledged for who they are culturally (Tuuta et al., 2004; Bishop et al., 2003). The Sexuality Education Guide, reviewed in 2015, was produced to assist schools to deliver their sexual education. The guide specifically mentioned seeking contributions from Māori students, whānau and the Māori school community to ensure sexuality education remained "culturally relevant and whānau focused" (MOE, 2015, n.p). The inclusion of Māori values and Māori knowledge into the sexuality education programme is another avenue for teaching customary Ngāi Tahu birthing rituals and practices and aligns with the Sexuality Educational Guidelines.

Indigenous Offerings

Exploring the similarities between Māori customary birthing practices and rituals and those of the First Nations and Inuit peoples in the cross-cultural review fostered a deeper appreciation and understanding of how colonisation impacted other cultures and validated how vitally important creation knowledge and customary practices are for the wellbeing and survival of cultural identity. Connection through shared experiences is empowering and removes some of the isolation experienced when dealing with loss caused by colonisation. The exchange of stories that speak of Indigenous people's inability to self-determine their lives is overwhelming, yet the collective fortitude to address racism and discrimination is equally rousing.

Creation mythology about First Nations, Inuit peoples and Ngāi Tahu contain similar symbolism, environmental phenomenon and divinities aligned to reproduction, childbirth and survival. The enlightening concept of cosmological layering from potential or the void, the densities of Te Pō and the world of light heralding creation and birth sits across Indigenous stories throughout Canada and New Zealand. The mythical stories and deities who represent creation reinforce the value of the universal mother, earth mother or Papatūānuku. She held the sacredness of regeneration and the survival of cultures. First Nation, Inuit peoples and Ngāi Tahu held women in such high esteem as pillars of strength and givers of life. Overtime, colonisation and assimilation chiseled away at the realm of womanhood. The strength once owned by wāhine waned and childbirth practices were handed over to non-Indigenous collectives to lead. Fear of their own ability to birth crept into the psyche of many Indigenous women and can be contributed to some of the knowledge loss experienced today (Barlow, 1991; Beatties, 1990; Benoit, 2001; Gonzales, 2012; Marsden, 2003).

The retention of cultural knowledge has been extremely difficult for the Indigenous people of Canada. They have been subjected to numerous legal obstacles since the 19th century, such as The Gradual Enfranchisement Act in 1869 which gave the government the power to remove unique distinction or rights of a First Nations person and force First Nations to assimilate to the larger non-Indigenous settler population (Bartlett, 1980; Daniel, 2013; Milroy, 1978; Woodward, 1994). Further amendments to the

Indian Act forced First Nations children to attend industrial or residential schools between 1894 and 1920, and stopped traditional ceremonies, such as the potlatch ceremony in 1884 (Daniel, 2013; Woodard, 1994). The Royal Commission on Aboriginal Peoples in 1996 found that the Indian Act was oppressive to the Indian people and their culture and the Commission described the Act as a source of assimilation resulting in cultural devastation (Dussault & Erasmus, 1996; Asch, 1984; Bornous, 2002; Canadian Studies Programme, 2007; Government of Canada, 2017).

Ngāi Tahu similarly have been subjected historically to land alienation and suppressive legislation that has shaken the very foundation Ngāi Tahu had established. The land purchases in the Ngāi Tahu takiwā (tribal area) such as, Ōtākou, Canterbury and Rakiura equated to the loss of 138,000 sq km's of land. The intricate legislation and societal rules disadvantaged Ngāi Tahu from entering a fair debate. Like the First Nations and Inuit peoples these oppressive government led and socially backed stipulations had profound impacts on all customary practices (Anderson and Tau, 2008; Beazley, 2017; Belich, 1996; Lux, 2016; Milroy, 2008).

Traditional midwives were highly respected because their work aligned with the work of the creator (Benoit, 2001). Benoit added that women who became midwives were said to have a calling to the profession. Their role as a midwife was to not only deliver the babies, but also to pass on ethical and moral values. The removal of the lay midwife role or birthers within Indigenous communities has undermined the value that Indigenous women have owned within the birthing realm, and this hastened the loss of traditional birthing knowledge (Benoit et al., 2012, 2015; Cidro & Neufeld, 2017). A representative of the National Aboriginal Council of Midwives said:

...reclaiming these practices that are ours is really profound, I think it goes beyond avoiding evacuations. It's a much deeper, more profound revitalization and reclamation. It's becoming self-determined again (2018, n.p).

Although many Ngāi Tahu kaumātua struggled to recall detailed knowledge about customary birthing practices and rituals they did recall the ruahine or elders who were renowned for their midwifery skills. Kaumātua could recollect these tane and wāhine by their names, and spoke of them as such valued members of the pā. They were acknowledged for their strength, knowledge pertaining to childbirth and tikanga

practices and their unselfish commitment to whānau. Like the First Nations and Inuit people our ruahine and lay midwives held iwi knowledge not only about life but also about death preparation and rituals (Benoit, 2001; Croft, 2020; Dacker, 1990).

Canada currently has 13 midwifery practices and initiatives that have been primarily established to meet the needs of the local Indigenous communities (Cameron, 2005; NAHO, 2008; Rogers, 2014). Similar to New Zealand, Canada is experiencing a shortage of midwives. The Indigenous midwifery workforce shortage in Canada restricts the capacity to fully reestablish Indigenous midwifery (Association of Ontario Midwives, 2019; Balkinsoon, 2018). There is a request by existing Indigenous midwives to increase Indigenous midwifery education opportunities and, in particular, community-led midwifery training programmes with ongoing devoted funding that will eventually lead to more equitable maternity outcomes and the restoration of Indigenous midwifery provision (Balkinsoon, 2018; Association of Ontario Midwives, 2019). In Te Waipounamu (South Island) we have two tertiary education providers who deliver the Bachelor of Midwifery Degree. Both providers appear to be making steps to be more inclusive of te Ao Māori practices within the midwifery curriculum and both offer Tūranga Kaupapa, but more specific customary birthing knowledge exploration should be prioritised. Ngāi Tahu need more registered midwives in all maternity settings (Kani, 2011).

The learning achieved from looking beyond Aotearoa to the First Nations and the Inuit peoples has been invaluable. Other organisations have also strengthened their Indigenous networks, such as Ngā Maia Māori Midwives Aotearoa with Indigenous midwives as invited guest speakers and Ngā Maia members in attendance at Indigenous Midwifery conferences and forums. The Ngāi Tahu Research Centre at the University of Canterbury has established a reciprocal teaching fellow with First Nations academic representatives delivering presentations and lectures sharing their areas of expertise. These opportunities alongside other Indigenous initiated exchanges continue to share Indigenous knowledge systems, disclose the challenges to retain cultural values and rights, and impart Indigenous solutions going forward.

8.7 Section Seven: The learning along the way

Ko ngā mea tepenga (limitations)

My research had four key tepenga in respect of data repositories and data acquisition. I will discuss each of these in turn.

The first critical limitation within my research was the lack of living repositories able to provide in-depth knowledge about customary Māori birthing practices and rituals. A telling reality was that many kaumātua who may have been able to share knowledge have since passed away and those who remain were not familiar or confident enough to talk in length about this specific kaupapa. The realisation that there were so few tāua and poua who knew anything about customary birthing rituals and practices was a poignant reminder of the assimilation inflicted upon Ngāi Tahu. Many said they wished they knew more about customary birthing practices to be able to pass it on to their mokopuna.

I lost four of the six kaumātua I had in the rōpū tautoko, and three research participants highlighted to me how important it was to keep gathering knowledge in multiple platforms from our living repositories before they join the realm of Hine-nui-te-pō.

The second limitation was the deficiency in literature on customary Māori birthing practices, and even less literature specific to Ngāi Tahu. I went to the Hocken Library in Dunedin and waded through manuscripts and approached the Alexander Turnbull Library in Wellington for archival materials. Finding relevant literature references was problematic when they were not listed as index items. Therefore, gathering pertinent literature required reading a wide range of Māori social histories or relying on biographies of past Māori dignitaries to include a description, if available, of their birth. Only some literature sources provided details of knowledge transmission to impart to the child in utero but even fewer described traditional childbirth practices.

Manuscripts were mostly written by men and non-Māori men and, therefore, this topic was not something they perhaps felt comfortable relaying in detail or indeed knew about in great detail. The karakia dictated in the manuscripts sometimes by Pākehā

historians were dubious in their accuracy. Sometimes the historian wrote phonetically what he had heard, others interpreted the karakia or waiata rather than a direct translation. It was difficult to know who had guided the transcription. The Māori transcripts were difficult to read also because the old writing font and the age of the document meant words would appear joined and lettering difficult to decipher. The context was often missing, so names of people, places or objects were unfamiliar. The older style te reo Māori is different to the styles that are taught today. Words, phrases and omissions made the translation difficult, and this was also felt by a Māori translator. Therefore, the translations offered are given as an overall understanding and are not be taken as being exact. Others with more contextual knowledge and te reo Māori fluency may claim more detail and accuracy than I was able to muster.

Therefore, the challenge became finding strands of information that provided evidence of practices and rituals that were executed in Te Waipounamu particular to Ngāi Tahu iwi and hapū. This led to exploring other knowledge platforms, such as the arts, including waiata and pūrākau to discover information embedded in art symbolism and other mediums.

The third limitation was the social conditioning and hospital regulations around birth that were imposed on fathers from the 1960s to the mid 1970s. The sterility of birth in the hospital at this time included restrictions placed on fathers, which resulted in all being relegated to the waiting room. Some older tane Māori (Māori men) in my study cohort believed that birthing knowledge was privileged to wāhine and the doctors only and, therefore, they did not want to or perhaps were not able to share their thoughts and knowledge on this kaupapa. The whole issue of men during this era being blocked from their partners' pregnancy and childbirth would constitute another piece of research by itself, as the reality for the men I spoke to about this was profound and their experience often filtered through to their sons.

The fourth limitation was my enthusiasm for this kaupapa, which entailed an overzealous scope of time. This resulted in the research providing an overview of many historical events, as opposed to investigating in more detail and deeper analysis of specific time periods. The rationale for including both historical and contemporary perspectives was to understand what Māori childbirth customs were and why Ngāi Tahu stopped these practices; and then, with my health practitioner pōtae (hat) on, I wanted

to know how we could integrate this specific knowledge into current midwifery training and maternity services to provide a culturally-endorsed birthing plan option.

Below are areas of research relevant to this kaupapa that could be further explored:

More study including a literature review is needed to gain greater insight into specific rongoā (natural Māori remedy) for childbirth and maternal wellbeing. What were the rongoā and what were they used for? Investigating the medicinal purpose and the practices of rongoā associated with ritual and childbirth will provide greater detail and opportunities to reintroduce these resources alongside the revitalisation of other customary birthing practices.

More study would be invaluable to access more Ngāi Tahu waiata and karakia that were used for conception, pregnancy, and birth. The richness in these taonga as resources and repositories of information has not been exposed fully in this thesis. To provide an infantry of waiata and karakia Ngāi Tahu for whānau to access, learn and bring to life again would contribute greatly to this kaupapa.

Research that delves deeper into the benefits for whānau Māori who attend Kaupapa Māori antenatal classes will provide evidence to entice more funding. More Kaupapa Māori Antenatal programmes and the capacity amongst Māori to facilitate these are needed to make customary birthing knowledge accessible to whānau. The kaupapa Māori antenatal programmes that are already functioning in are communities are successful, but they are often positioned around one or two passionate and overworked Māori LMCs). Therefore, there is a risk of programmes discontinuing if more capacity is not grown, evaluation data not gathered and training supported (Kelly, 2019; J. Te Huia, Ngāti Kahungunu, Māori Midwife)

Ngā mea kaha (strengths)

Research “pearls” are unplanned and gracefully come through the research data. They may not manifest into a research theme but are positive observations that contribute to the spirit of the research.

Mana Hākui

The beauty of gathering tāua together to talk about traditional birthing practices and rituals gave many the opportunity to share their own birthing stories. This was a therapeutic process for both the researcher and tāua, and a precious piece of this study. Imparting stories that had not been shared previously established rapport between me and the interviewees. I valued the trust and respect that grew from these interviews. Although, I did not ask any of the research participants to share their own birthing experiences, many of them did, and in doing so they seemed to have a greater memory recall about childbirth stories associated with their mothers and grandmothers.

What was not captured in this thesis, nor via any audio recording, is the emotion evoked from these wāhine when talking about a kaupapa they have not shared. The childbirth experiences that ended with death, the loss of children due to sickness, and the naivety of many of them with menstruation, puberty and sex. As tāua, they giggled, they appeared bashful and beautiful. It was as if I was talking to them as a young woman of 18 years. Portraying the essence of wāhine through their birth stories is not what can be seen or heard, it is what is felt in interviews. These pearls can be the hardest to articulate.

Kaupapa Māori Methodology

Kaupapa Māori theory as a methodology allowed this thesis to breathe and hold my integrity as a Ngāi Tahu wāhine in this body of work. The kaupapa Māori principles provided the overall guidance but respected the uniqueness of iwi and of the researchers. Eketone (2008) questioned what happens once the kaupapa Māori theory and research approach has been achieved. He further asserted, if kaupapa Māori is about critiquing the power imbalance in relationships, once this has been highlighted where to from there? In terms of this doctoral thesis, by exploring a contemporary element of Māori, such as midwives and midwives in training, the “where to from here” is given voice. This attention to the contemporary drew changes most beneficial to Ngāi Tahu.

Kaupapa Māori challenges the current ethical guidelines that can dictate research approaches. Sometimes these ethical guidelines do not incorporate the Indigenous

voice. Through the information sheet and in the written and verbal explanation to participants about the disposal of recorded data. I was able to provide options to participants that allied more closely to Māori values. To enable disposal options I engaged with the Hocken Library Kaitiaki Mātauranga Māori (Māori Librarian) to create a formal agreement to store the digital interview recordings at the Hocken Library for those participants who chose this option. This material would be available for whānau to access and to the public after ten years post thesis submission. Participants could choose to have the data returned to them or to be gifted to the Hocken Library for preservation and archiving, or for their data to be disposed of. The majority of the 29 participants wanted their digital recordings to go to the Hocken Library. None of the participants wanted their digital recordings destroyed. This is a strength and cultural flexibility that is afforded in kaupapa Māori. Allowing for both the researcher and the participant to feel comfortable that the options provided for participants acknowledge the mana of the data and their whakapapa.

Kaupapa Māori principles of “Ata”, “Kaupapa”, “Taonga Tuku Iho” and “Tino Rangatiratanga” display qualities of approach, research content, whakapapa and sovereignty. Upholding not only the mana of the research participants and their whānau, but also those they speak about and *their* pūrākau, has been best met with this methodology. Sharing my own whakapapa, karakia, waiata and pūrākau has been personally enlightening. To read the words my great-grandfather expressed when he represented the hapū and iwi on issues of land alienation, poor health, education, and injustices of legislation was bitter-sweet. Hearing scant and sometimes diminutive snippets of information about my tūpuna wāhine was reflective. Emphasising how they were perceived in society, who gathered the information and how muted their voices were post colonisation. Kaupapa Māori allowed these tensions to be uttered and understood.

A muri ake nei mahi (after the completion of this work)

The seven kaupapa Māori research principles used throughout this kaupapa continue to offer guidance as the project comes to a close. In honour of the principle Ata, it is

essential to return this thesis to the people who contributed their knowledge. In reverence of the rōpū kaumātua, the research participants and their whānau, Rapaki and Arahura Marae, presentations of the findings will take place, and a written summary and mihi will be sent to the participants. I plan to provide a short series of presentations to key organisations that have been supportive in this journey, for instance, Rapaki Māori Women's Welfare League, Ōnuku and Koukourarata Rūnanga.

What beleaguered this kaupapa and facilitated my master's and PhD journey, was the scarcity of resources. There are too few brochures in the maternity services or websites that provide information about traditional Māori birthing practices. The pool of people who do know about this knowledge are few, and often not Ngāi Tahu. This thesis explained what led to the decline in birthing knowledge and it can also champion some practical steps forward. Therefore, following the completion of this doctorate thesis, I will be seeking funding to produce an app (or preferred medium) resource for South Island maternity centres. This is the second step of the dissemination process that will make this knowledge accessible and visible.

Step three has been an intention since the completion of my master's film, *Iho – a cord between two worlds*, in 2011 to develop a multi-media Ngāi Tahu dance (all Ngāi Tahu crew) performance. The imagery that has shone through the manuscripts, waiata, karakia and other Māori art forms begged for an atamira (stage) to creatively illustrate some of the key learnings from this thesis.

8.8 Section Eight: Karawhuia (Let's do it – time to move)

Kupu Whakamūtungā (Conclusion)

A central motivation for exploring customary knowledge and practices is that knowledge begets Ngāi Tahu whakapapa, Ngāi Tahu identity, and Ngāi Tahu wellbeing. Take it away and what is left? Bring it to the fore again and watch the realms of our whakapapa connect. Witness the people flourish, knowing that they have begun their own journey, not one dictated by other philosophies or ways of knowing but by claiming tino rangatiratanga over their own cultural values and knowledge sources (Campbell, 1988; Tikao, 1990; Tiramorehu, 1987; Marsden, 1992, 2003).

Customary birthing knowledge, rituals and practices for whakairatanga (conception), hapūtanga (pregnancy) and whānau mai (birth) remain vitally important for self-preservation and the mana of Ngāi Tahu. Modern technology or Western models of health should not replace the layers of cultural knowledge imparted to the pēpi (baby) and mother via natural platforms. These are podiums of mātauranga Ngāi Tahu that infuse awareness of self and place.

As the entity of Ngāi Tahu and the members within its fold develop and resurrect from historical trauma, the Ngāi Tahu creation stories, practices and mātauranga must be at the forefront of this empowering movement. Linda Tuhiwai Smith (1999) stated that Indigenous cohorts are in agreement that history is not only essential in understanding the present time but critical in contributing to the decolonisation of the iwi. Ngāi Tahu and the Papatipu Rūnanga (18 regional councils of Te Rūnanga o Ngāi Tahu) endeavour to view their future through cementing what we know of our history for cultural growth, and to be self-determining.

Given that our landscapes and seascapes remain, so lives on the repositories of mātauranga Māori. It is how we actuate this knowledge that brings it to the fore and makes it important in our lives again. Therefore, Ngāi Tahu customary birthing rituals and practices have not been lost but await whānau activation. Indigenous scholars, such as Graham Smith, Leone Pihama, Ganesh Nana, Michael Yellowbird, Dara Kelly, Jimmy Woon, Bonnie Duran, Patrisia Gonzales Ani Mikaere and Linda Tuhiwai Smith

have all reminded us that our ancestors have left us a legacy of knowledge. It is in our blood, our bones and our DNA to understand loss of land and of lives, but it is also in us to know strength and courage. Throughout my thesis writing, I have experienced in Ōtautahi (Christchurch) the Port Hill Fires in 2017, the Mosque shooting in 2019, Covid-19 lockdown in 2020 and numerous disturbing incidents that incited further fight and flight reactions. I personally attended too many tangihanga of respected pillars in the Māori community here and in other rohe (areas). These times give charge to the legacy we have been left and now is the time to reclaim, revitalise and reactivate traditional knowledge and rituals. This is a chaos period (Covid-19) spoken of in creation mythology. It has forced the world to rest as we grapple with what this all means and what will be.

History has shown us with the antonine and bubonic plague pandemics pre-14th century; cholera; influenza throughout the 19th and 20th centuries; HIV AIDS; and Covid 19 in the 21st century, to name a few disease colonisations, that in this human centric world we are merely guests. As Indigenous scholars Dara Kelly and Karmen Crey reiterated, “the earth had dominion before us, and it will after us” (2020). How we learn to live with the unseen invaders, how we protect the whenua will be inherited by our mokopuna. Evison (1993) avowed that the whenua serves not only as an economic commodity, but it is foremost the urupā (burial ground) of our tupuna, the whenua (placenta) of a pēpi and the domicile of our atua. Therefore, a place of standing, of tūrangawaewae to affirm cultural identity (O’Regan, 2001).

Campbell (1988) and Tau (2017) reiterated that rituals are an enactment of mythology. Ngāi Tahu birthing practices are also enacted rituals of the universal mother, Papatūānuku, and the atua in place to guide Māori through life.

The concept of whakapapa as a symbol of Māori identity is directly related to land. Descent is commonly traced back to Papatūānuku, further serving to strengthen that bond (O’Regan, 2001, p.50).

Ngāi Tahu were deeply affected by the impact of colonisation and consequent assimilation, land alienation, broken promises, loss of income and wealth, and poor health. They were once governors but in a relatively short period of time they became victims of misgivings. However, the tenacity of the iwi members to survive against the

odds is beyond belief though not without sacrifice and extremely hard work. Ngāi Tahu members advocated for their hapū and iwi to the Crown and settler government again and again, over the generations. That resulted in the Deed of Settlement in 1997, which did not replace all that was lost but it allowed the iwi to rebuild. However, in the process of restoration, we were distracted in nurturing some of our most crucial rituals that brought us into this world and set us up on a solid foundation. Customary birthing rituals and practices have been smothered in the course of righting the wrongs of the past. When Ngāi Tahu address health issues for the iwi, customary birthing stories, rituals and practices need to be at the forefront of healing and nurturing the iwi.

Mana to our wāhine Ngāi Tahu whānui, whilst overcoming the sharpest end of social discrimination, they are also charged with the recuperation of their tūrangawaewae (place of standing), ūkaipō (source of strength) and pūrākau (stories) in the realm of childbirth. The arena of birthing practices and ceremonial rituals are wāhine-led, however, guided by our atua and shared with tane and whānau. The return to these rich and wise customary practices needs to be driven by the hā me te ihi o ngā wāhine (the breath and energy of women). I concur with this kōrero, and prefer the terms liberate, extricate, emancipate the mātauranga Ngāi Tahu and the mana of wāhine Ngāi Tahu, as opposed to terms like: (de)colonise, (de)cline, (de)moralise or (de)mote to suggest a few. The linguistics of our liberation need to be what we use, choose and prefer to speak to express our pūrākau whānau (birth story).

To conclude, I contend that in having a greater awareness of, and encouraging the use of ancestral knowledge specific to customary Māori birthing practices, there will be a positive impact on the life course, cultural identity and wellbeing of Ngāi Tahu whānui.

Orokohanganga

Ko Io whakatata

Ko Io whatamai

Ko Hekeheke i nuku

Ko Hekeheke i papa

Ko Te Korekore ka ahu mai ka Pō-takiwā

Nō ka Pō-takiwā ka ahu mai ka Ao katoa

Ka puta ki waho, ki roto i tēnei ao mārama

He takata hou ki te whaiao

Ki te ao mārama

Tihei mauri ora

Appendices

Appendix A: Research approval letters

- i) University of Canterbury Ethics Committee Approval
- ii) Māori Research Advisory Group
Consultation Response

Appendix B: Information and Consent Sheets

- (i) Participant Information Sheet
- (ii) Participant Consent Form

Appendix C: Promotional Resources

- (i) Masters film, “Iho- a cord between two worlds”:
<https://youtu.be/1Qm0c00Aklk>
- (ii) Presentation opener: <https://youtu.be/tOucxVS8gZo>
- (iii) Presentation closer: <https://youtu.be/JBIzndcLFko>

Appendix D: Research Enquiry

- (i) Qualitative Research Questions

Appendix A: (i)



HUMAN ETHICS COMMITTEE

Secretary, Lynda Griffioen
Email: human-ethics@canterbury.ac.nz

Ref: HEC 2015/46

20 July 2015

Kelly Tikao
School of Health Sciences
UNIVERSITY OF CANTERBURY

Dear Kelly

The Human Ethics Committee advises that your research proposal "Raro-timu, Raro-take - conception, creation and customs pertaining to Ngai Tahu traditional birthing knowledge" has been considered and approved.

Please note that this approval is subject to the incorporation of the amendments you have provided in your email of 13 July 2015.

Best wishes for your project.

Yours sincerely

A handwritten signature in black ink, appearing to read 'L MacDonald'.

Lindsey MacDonald
Chair
University of Canterbury Human Ethics Committee

Appendix A: (ii)

Māori Research Advisory Group

Consultation Response

May 6th, 2015

Tēnā koe, Kelly

Re: Traditional Māori Birthing Practices

This letter is written on behalf of the Māori Research Advisory Group (MRAG). It acknowledges that your proposal has been reviewed by MRAG. I am pleased to advise you that the committee have expressed support for your project, and we wish you well as you work on this ambitious and important topic. We will be happy to provide any further advice and support that you might need as the work progresses. One committee member took a particular interest in your project and made the comments below for you to consider.

This application is as thorough as I have read and encompasses a vast array of perceptions of birthing. Kelly should be congratulated for her approach and for her willingness to attend to this topic. There is only one issue that I would respectfully ask Kelly to take care to acknowledge (I am not suggesting she has ignored it) and that is that across the motu and that across Te Ara a Kiwa to Rakiura where my own family lived until the late 1800's birthing approaches were variable depending on the season and the geography and the family. i.e. there was no one style or method that was carried out by all. Whānau applied different methods, pa had different approaches as you might expect. Kaika at the southern part of Port Adventure and Onekia on the southern edge of Paterson's Inlet (Rakiura) were hours apart and of course whanau in Otakau, Kati Waewae and other places were likely to do things differently. Such places were as different as countries in Europe are. It would be impossible to discover all of the styles / methods of birthing except to say that they would have been very different.

I am in awe of the proposal and wish the researcher every success and look forward to her findings.

Thank you for engaging with the Māori consultation process. This will strengthen your research proposal, support the University's Strategy for Māori Development, and increase the likelihood of success with external funding applications. It will also increase the likelihood that the outcomes of your research will be of benefit to Māori communities. We wish you all the best with your current project and look forward to hearing about future research plans.

The MRAG committee would appreciate a summary of your findings on completion of the current project. Please feel free to contact me if you have any further questions.

Nāku noa, nā

A handwritten signature in cursive script that reads "Tracy Rohan".

Dr Tracy Rohan

Research Consultant Māori

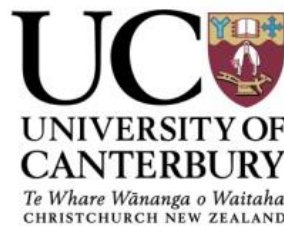
Research and Innovation

Room 244, Level 2, Psychology Building
ext 45520

Email: tracy.rohan@canterbury.ac.nz

Office Hours: Wednesdays 12.30- 5.00 pm, Thursdays and Fridays 8.00am to 4.30 pm

Appendix B: (i)



Kelly Tikao's Doctoral Research Project
School of Health Sciences
University of Canterbury

**Raro Timu Raro Take
Conception, Creation and Customs
Waitaha, Kāti Māmoe and Kāi Tahu Birthing Traditions**

PARTICIPANT INFORMATION SHEET

Ko te reo uruhau tēnei e mihi atu nei, e kore e mutu kā mihi.

Thank you for showing an interest in this project. Please read this information sheet carefully before deciding whether or not you would like to participate. If you decide not to take part there will be no penalty or disrespect shown to you at all and I thank you very much for considering my request.

What is this research project about?

In 2013, I completed my Masters degree in Science Communication at the University of Otago my thesis for this degree explored traditional Māori birthing practices and how important and relevant this knowledge still is in the delivery of maternity care in Aotearoa.

I am still intrigued with this kaupapa (subject) and I am eager to research it further within my doctoral studies, in particular, tikanga (traditions) and kawa (ceremony) associated with ngā hapū o Ngāi Tahu and their conception and birth knowledge. I am interested in finding out how these practices were undertaken, by whom and how best do we reintroduce and relearn some of these old practices for the betterment of te iwi Ngāi Tahu.

Also, to enquire if Māori birthing practices can be brought into the tertiary training of all midwives and also into the competency requirements of the Midwifery registration. So that a greater number of midwives can support Māori birthing tikanga and that these practices are viewed as safe and important options to make available for all whānau.

Who will be conducting the research?

My name is Kelly Tikao and I affiliate to these hapū: Kāti Irakehu, Kāti Kahukura, Kāti Hine Kura, Kāti Tuhaitara, Kāti Tuahuriri and Kāti Wheke, of which, align to these iwi: Waitaha, Kāti Māmoe, Kāi Tahu.

This research project is being carried out as a requirement for my PhD degree and I will be conducting all components of this study such as:

- arranging the interviews
- setting up the recording equipment (Dictaphone and /or Camera)
- conducting the interviews
- transcribing the interviews
- ongoing communication with the participants
- collecting and collating data and data analysis
- writing the doctoral thesis, publications and oral presentations pre and post-doctoral completion.

Who will the participants be?

This research project aims to talk to individuals and groups of mature Māori wāhine and tane that would like to share their stories, memories and mātauranga (knowledge) pertaining to Ngāi Tahu traditional Māori birthing practices and tikanga.

What will happen at the interview?

I will be recording the interview via a digital dictaphone (a small digital device smaller than your hand) and the interview may be filmed. The video camera is also a small device and will be placed upon a tripod discreetly to the side. You can decline from the film recording.

The interview with the participant will take up to two hours and will take place at a location most suitable to you such as: your own home, in a park, at the Marae or an arranged space in the community.

You can kōrero Māori or Pākehā in this interview I am comfortable with both languages but may have to seek translation in certain parts.

Once you have been interviewed, I may need to call or email you to seek further clarification on what was said in the interview. This will help ensure that I have understood all of your kōrero. If I need to make a phone call to you, I will ensure that it is brief and again at a time most convenient to you.

Your interview will be transcribed and a copy will be sent to you to check and provide any further feedback.

What will the photographs and film footage be used for?

The photographs and film footage will potentially be used within the body of the thesis and as a tool for dissemination of the research findings. What is already known about this kaupapa is that there is not enough resources available for whānau to help them

incorporate traditional Māori birthing practices into their own pregnancy and birthing experience. I would like to produce a written and visual resource from the research findings for whānau available via maternity services at the completion of my doctoral thesis. Acknowledgement on all resources will be aptly given to those involved. You can at any time decline from having your photograph and/or film footage taken during your interview with no judgement or penalty to you.

Do I get a copy of the research results?

A Summary of the Research will be written after the handing in of the final doctoral thesis (2018) and each participant will receive a copy of this and of any images (including film footage) of the participant taken throughout the research process. The doctoral thesis will be published, and copies will be available in the University of Canterbury Library and via the author directly.

The thesis produced from this study is a public document and will be available through the University of Canterbury Library.

Will I be identified in this research?

This is your choice – when you complete the Consent Form you can let me know how you would like to be identified in this study.

If you do not want to be identified in this study your name will be coded and all documentation will retain your anonymity. I am the interviewer, researcher and transcriber and this helps maintain confidentiality, as there will be no one else handling the data.

How will my information be protected?

Your information will be stored in a locked cabinet in a locked office and electronically in a password protected external hard drive that will also be kept in the locked cabinet when not in use. This data will be kept for ten years by the researcher and after this allotted time there are three options available to you for its return. These options include the following:

- for all your data including photographs and film footage to be returned to you
- for all your data including photographs and film footage to be archived at the Hocken Library (Dunedin) which will make the data accessible to the public
- for all your data including photographs and film footage to be destroyed

These options are outlined in the Consent Form and can be discussed thoroughly with myself and/or my Supervisors prior to completing the Consent Form.

What if I get upset during the interview?

At any time you can refuse to answer any of the questions asked of you and you can also ask me to stop the interview. If you feel that you require more support post our

interview listed below are two external services that may be of assistance.

Healthline – 0800 611 116

Samaritans – 0800 726 666/0800 211 211 or 04 473 9739

Ngāi Tahu Rūnanga

Kaikōura Rūnanga Adan Te Huia Ph: 03 319 6523 Em: adan.tehuia@ngaitahu.iwi.nz

Ngāti Waewae Rūnanga Ph/fax : 03 755 6451 Em: panui@ngatiwaewae.org.nz

Te Rūnanga o Makaawhio Ph: 03 755 7885 Em: makawhio1@xtra.co.nz

Te Ngāi Tūāhuriri Rūnanga Ph: 03 313 5543 Em: tuahiwi.marae@ngaitahu.iwi.nz

Ōnuku Rūnanga Ph: 03 366 4379 Em: onuku@ngaitahu.iwi.nz

Te Rūnanga o Koukourārata Ph: 03 365 3281 Em: koukourarata@ngaitahu.iwi.nz

Wairewa Rūnanga Ph: 03 377 1513 Em: wairewa@ngaitahu.iwi.nz

Te Hapū o Ngāti Wheke (Rāpaki) Ph: 03 328 9415 Em: rapaki@xtra.co.nz

Te Taumutu Rūnanga Ph: 03 371 2660 Em: taumutu@ngaitahu.iwi.nz

Te Rūnanga o Arowhenua Ph: 03 615 9646 Em: arowhenua@xtra.co.nz

Te Rūnanga o Waihao Ph: 03 689 4726 Em: waihaomanager@gmail.com

Te Rūnanga o Moeraki Ph: 03 439 4816 Em: moeraki.runanga@xtra.co.nz

Kāti Huirapa Rūnaka ki Puketeraki Ph: 03 465 7300 Em: admin@puketeraki.co.nz

Te Rūnanga o Ōtākou Ph: 03 478 0352 Em: office@tro.org.nz

Hokonui Rūnanga Ph: 03 208 7954 Em: hokonui@xtra.co.nz

Waihōpai Rūnaka Ph: 03 216 9074 Em: info@waihopai.org.nz

Ōraka Aparima Rūnaka Ph/fax: 03 974 0215 Em: office@orakaaparima.org.nz

Awarua Rūnanga Ph: 03 212 8652 Em: awarua@xtra.co.nz

Who owns the information I share in the interview?

You own your own kōrero and through the Consent Form I will seek your permission to potentially include your kōrero or photographs and film images taken during the interview into my doctoral thesis.

If you have not indicated on the Consent Form that you would like to remain anonymous I will always ensure that your information is correctly acknowledged in the doctoral thesis.

You will always retain the intellectual property rights over your knowledge and stories shared during this research project. However, the doctoral thesis written from the research project is the copy right of both myself (Kelly Tikao) and the University of Canterbury.

What if I want to withdraw from the study?

Participation is voluntary and you have the right to withdraw at any stage without penalty. Upon withdrawal from the study I will remove all information you have shared, including photographs and film footage. All data will be returned to you.

Who else can I talk to about this research project?

I will be available to respond to any questions or concerns you would like to discuss about this project:

Kelly's cell phone: 0274826324

Email: ktikao@unifone.net.nz

I am under the Supervision of Dr Sonja Macfarlane

(sonja.macfarlane@canterbury.ac.nz), Associate Professor Merata Kawharu

(Merata.kawharu@otago.ac.nz) and Associate Professor Te Maire Tau

(temaire.tau@canterbury.ac.nz). They can also be emailed to discuss any concerns or questions you may have about your participation in this project.

This project has been reviewed and approved by the Māori Research Advisory Group and the University of Canterbury Human Ethics Committee, and participants should address any complaints to The Chair, Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch, (human-ethics@canterbury.ac.nz).

What do I do if I would like to be a participant?

You will need to complete a Consent Form and return this to me (in person, via email or in the stamped self-addressed envelope provided) and I will then call you to arrange an interview date/time and venue.

Appendix B: (ii)



Kelly Tikao's Doctoral Research Project
School of Health Sciences
Telephone: 0274826324
Email: ktikao@unifone.net.nz

Raro Timu Raro Taki Conception, Creation and Customs Waitaha, Kāti Māmoe and Kāi Tahu Birthing Traditions

PARTICIPANT CONSENT FORM

Ki a koe te pitau whakarei...

I have been given a full explanation of this project and have had the opportunity to ask questions.

I understand what is required of me if I agree to take part in this research.

I understand that participation is voluntary and I may withdraw at any time without penalty. Withdrawal of my participation will also include the withdrawal of any information including photographs and/or film footage that I have provided.

I understand that I will be given the opportunity to be identified or for my identity to be kept anonymous. I have ticked the correct box below that I agree with.

Any published or reported results will only identify myself if I have agreed to be identified. I understand that a thesis is a public document and will be available to students and staff via the University of Canterbury library.

I understand that all data collected for the study will be kept in locked and secure facilities and all electronic data will be password protected and kept in a locked filing cabinet. I understand that the researcher will hold onto my data (inclusive of photographs and film footage) for ten years and that I can select what I would like to have happen to this data after the 10 years with the options provided below.

I understand the risks associated with taking part and how they will be managed.

I understand that I am able to receive a Summary of the Research findings once Kelly Tikao has completed her thesis.

For further information I know I can contact Kelly Tikao on:

Email: ktikao@unifone.net.nz

Cell: 0274826324

or Kelly's Supervisor: Dr Sonja Macfarlane

Email: sonja.macfarlane@canterbury.ac.nz

Phone 03 364 2987, Extn 7628.

If I have any complaints, I know I can contact the Chair of the University of Canterbury Human Ethics Committee, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

By signing below, I agree to **participate in this research project**.

Name: _____

Contact Address: _____

Phone: _____

Cell: _____

Email: _____

Signature: _____

Date: _____

Identification

I agree to the following identification in all written documentation associated with this research:

✓ *Please tick the correct box*

- ☐ My name and iwi
- ☐ My name only
- ☐ My iwi only
- ☐ To remain anonymous

Photographs and Filming

I will be taking photographs of the research participants and also filming some of the participants during the research interviews. The audio data, photographs and the filmed footage will contribute to the doctoral thesis and will assist in the dissemination of the research findings.

I would also like to produce a written and visual resource from the research findings to be shared with whānau via the community maternity services. Being photographed and filmed whilst being interviewed is in addition to this research project. There is no pressure for you to agree to this, as your participation in the research is foremost, regardless of the optional additions.

Do you consent to being photographed for this research project?

☐ Yes ☐ No

Do you consent to being filmed for this research project?

☐ Yes ☐ No

Disposal of Data

I agree to the following options in regard to what will happen to my recorded data including photographs and film footage after the mandatory ten years of storage preservation:

- ☐ My data inclusive of photographs and/or film footage will be sent back to me at the above address.
- ☐ My data inclusive of photographs and/or film footage will be gifted to the Hocken Library (Dunedin) as an archival repository accessible to the public for research.
- ☐ My data inclusive of photographs and/or film footage is to be disposed of.

Thank you for filling out this Consent Form and for carefully considering your options. Can you please keep the Information Sheet and return the completed Consent Form to Kelly Tikao (Researcher) in person or place the completed Consent Form in the attached stamped addressed envelope or scan your completed Consent Form and email to: ktikao@unifone.net.nz

Kelly will call you on the phone number or email you have provided in a few days time to discuss the next stage of the project and to book a day, time and location of the interview.

Kei raro te korowai o te manākitaka, e kore e mutu kā mihi.

Appendix C:

- (i) Masters film, “Iho- a cord between two worlds”:
Removed content
- (ii) Presentation opener: Removed content
- (iii) Presentation closer: Removed content

Appendix D: (i)



Kelly Tikao's Doctoral Research Project
School of Health Sciences
Telephone: 0274826324
Email: ktikao@unifone.net.nz

Raro Timu Raro Taki Conception, Creation and Customs Waitaha, Kāti Māmoe and Kāi Tahu Birthing Traditions

QUESTIONS FOR THE PARTICIPANT

Ki a koe te pitau whakarei...

Background

- 1) Can you tell me a little bit about yourself?
- 2) No hea, whakapapa affiliations...
- 3) Where did you grow up?
- 4) Can you remember any stories around your own birth or anyone in your whānau whānui?
- 5) Can you remember any birthing stories from when you were a child, anything that stands out for you?

Ngai Tahu Kōrero

Knowledge of traditional Māori birthing practices specifically those associated with Ngāi Tahu.

Knowledge of traditional Māori birthing tikanga specifically those associate with Ngāi Tahu.

Knowledge of particular people's births within their whānau and hapū

Knowledge of karakia, waiata, oriori, kōrero, pakiwaitara that references conception, pregnancy and birth.

- 6) Can you remember any names of whānau or people in your village/kaik who were associated with birthing?

- 7) Can you remember anything told to you about karakia that had any conception, hapūtaka, birth connections in them? Can you recite any? Or have copies of karakia that mention anything about conception/birth?
- 8) Can you remember or know when certain karakia were done? By whom? Time of day? Did the kaikarakia use any tools/plants/trees alongside the reciting of karakia?
- 9) Can you remember anything told to you or witnessed by you about certain practices in relation to conception and birth?
- 10) Have you ever heard about specific birthing place, whare, trees, waterfalls etc in your kaik?
- 11) Have you heard about any rongoa? Plants, hinu, kai, vapour used for conception, hapūtanga and birth?

Hauora

Knowledge of hauora for Māori and what this may look like?

Knowledge of tikanga Māori and the relevance or lack of for Māori now and the future.

- 12) What are your thoughts around the hauora o te iwi Māori today?
- 13) Have you any thoughts around what could make us healthier?
- 14) Do you think understanding who we are as a people, identity, whakapapa, responsibilities to our whanau, tikanga (knowing and practicing certain tikanga) is hauora? And, why?
- 15) Do you think learning about and being aware of traditional Māori birthing practices may play a part in the uplifting of te iwi Māori hauora?

Indigenous Birthing Practices

Knowledge of other indigenous birthing practices.

- 16) Do you know any other indigenous birthing practices that you know a snippet or a great deal about that you might like to share?

Specific Art Questions

Knowledge of Māori birth symbols or concepts expressed in rock art.

- 1) Can you make some links from your knowledge of rock art to certain symbols and drawings that could allude to conception/creation/haputanga/birth? and if so which ones and why do you think this?
- 2) Can you show me which rock art drawings you are specifically talking about and provide their name, location and your thoughts about this particular drawing?
- 3) Is this a theme common in your opinion to the many rock art drawings?

- 4) What do you think these symbols and references to birth says about these ancestors?
- 5) What can you tell from what they drew was important to them?
- 6) What can we learn from these drawings and perhaps find relevance today?

Specialist in Contemporary and Traditional Art Forms

Knowledge of Māori birth illustrations in other traditional art forms such as whakairo and tukutuku panels.

- 1) In what art forms do you see conception/hapūtanga/birth portrayed more so than other art forms? Why do you think this is?
- 2) What messages are the art forms trying to express or the kaimahitoi of these art forms?
- 3) Traditionally, thinking about tukutuku, kōwhaiwhai panels and whakairo – what were our hapū, tohunga kai raranga trying to portray in these art forms pertaining to conception, hapūtanga and birth?
- 4) Were there any warnings or blessings or messages for those generations to follow? Did they convey how hapūtanga and birth may have been practiced/aided/perceived?
- 5) Are you aware of any particular art piece/picture/whare nui in Te Waipounamu that may have a particular art piece still insitu that I should find out about/go to?

Specific Midwifery Education Questions

- 1) What is being taught today in our midwifery schools to our midwifery students about traditional Māori birthing practices?
- 2) What are some of the barriers to including indigenous practices into the teaching of midwifery students?
- 3) If the issue is lack of information and resources and over the next few years this changed and more resources became available and more people available to lecture on this – would you perceive indigenous birthing practices in particular Māori be seen as a vital part of the students learning and midwifery practice? Can you elaborate on your thoughts to this?
- 4) Could Traditional Māori Birthing Practices ever become a specialist topic that all midwifery students get the option of learning and practising and then leave as a specialist in this area of midwifery (acknowledged and endorsed by the Midwifery Council)?
- 5) It has been mentioned by a number of Māori midwives that when they incorporate traditional Māori birthing practices into their care of their clients they run the risk of not meeting their registration requirements yet it is what

the whānau want – how can we get around this? Do the registration/competencies need to be looked at or are we looking at a separate registration that holds the same mana?

Glossary

A

Āhua - form

Ako - learn

Anga - shells

Aoraki - Mount Cook, Ngāi Tahu ancestral mountain

Aotearoa - New Zealand

Ao Tūroa - physical world

Aiki - chief

Ata - morning

Atua - god, deity

Atamai - shape

Atamira - stage

Ātea - space

Awa - river

E

Ewe - placenta, womb

Eweewe - blood relations

H

Hā - breath

Hauā - disability

Haka - war dance

Hakari - feast

Hākui - mother, elderly woman

Hāngi - earth oven

Hapori - small clan, community

Hapūtanga - pregnancy
Hapū - subtribe, pregnancy
Haonga - sandstone
Harakeke - flax
Hauora - health
Hine Nui Te Pō - Goddess of Death
Hinū - oil
Hoaka - sandstone
Huataki whakairo (pare) - door lintel
Hunga - people
Hungahunga - divide

I

Iho - umbilical cord
Io - Supreme God
Ioio whenua - Eldest son of Ranginui and Papatūānuku
Ipu whenua - placenta container/vessel
Ira tāngata - human element
Iriiri - to baptise
Iwi - tribe

K

Kaha - strong
Kaiārahi - guide
Kaimahi - worker
Kaik - Ngāi Tahu abbreviated reference to kaika (village)
Kaimahi - worker
Kainga - village
Kairaranga – weaver
Kaiwhakairo - carver
Kaitiaki / Kaitiakitanga - guardian
Kaiwhakairo - carver
Kaitito - composer

Kakahu - clothing or Kāi Tahu term for korowai
Kakunga whitau - flax fibre cord
Kāpo- blind
Karakia - incantation
Karamū - coprosma robusta
Karanga - a call often by a wahine during a pōwhiri (formal welcome)
Kaumātua- distinguished older Māori
Kaupapa- subject
Kawa - customs
Kawakawa - pepper tree
Kiri - skin
Koha - gift
Korahi - flint
Korowai - woven cloak
Koru - fern frond
Kotahitanga - being one, oneness
Kōwhaiwhai - rafter paintings
Kūmara - sweet potatoe
Kura - school
Kura kaupapa - immersion Māori school
Kutai - mussel

M

Mahinga kai - cultivation, food gathering place
Mahi raranga - weaving work
Mahora nui atea - Goddess of clearance, extention
Mana - prestige, integrity
Mana whenua - local people of the land
Māngai - mouth
Manutioreore - song bird
Maripi - knife
Mata - flint
Matā tuhua - obsidian

Mataku - curse
Mātauranga - knowledge
Maui - Pacific Demi god
Mauri - life principle
Mahinga kai - eating reservoir or source
Mihi whakatau - informal welcome
Mimi - urinate
Mirimiri - massage
Mokopuna - grandchild
Mōteatea - traditional song of lament
Moe - sleep
Muka - harakeke fibre
Murihiku - Southland

N

Namunamu - sandfly, saying for food being delicious
Nanakia - rascal clever
Ngā puna mātauranga - knowledge pool
Noa - common
Ngāi Tahu - South Island tribe
Ngāi Tarewa - subtribe of Ngāi Tahu predominantly based in Banks Peninsula
Ngaro - lost

O

Ōhākī - legacy
Ora - alive
Oriōri - lullaby
Ōtautahi - Christchurch

P

Pā - village
Pae - orators' bench

Pākehā - European
Papatūānuku - Earth Mother
Pātaka - food storage house
Pare - door lintel
Pēpi - baby
Pepeha - a tribal saying
Pipi - cockle
Pingao - golden sand sedge
Pito - umbilical cord nearest the baby
Poko haru a te Po - a wife of Ranginui the Sky Father
Pono - truth, valid
Poroporoaki - formal farewell, closing ceremony
Pōwhiri - formal welcome on tōjima
Pou - pole
Pūoro - musical instrument
Puhi - virgin
Pūrākau - story
Pure - birthing ritual
Puku - belly

R

Rakatira/rangatiratanga - chief
Rangahau - research
Ranginui/Rakinui - Sky Father
Raranga - weaving
Rauemi - resource
Rauru - portion nearest the placenta
Rehu - flint
Reo - language
Rimurapa - seaweed
Rongoā - herbal medicines
Rōpū - group

Romiromi - form of massage
Rongomatane - God of cultivated foods/agriculture
Rua - hole
Ruahine - elderly woman
Ruru - owl

T

Taiao - environment
Takarangi - spirals
Tamaiti - child
Tamariki - children
Tangaengae - another term for umbilical cord
Tāniko - tapestry
Taua - grandmother
Tauihu - prow of a war canoe
Taonga - precious treasure
Taonga pūoro - traditional Māori instruments
Takaroa/Tangaroa - God of the sea
Tapu - sacred
Tapuhi - midwife
Tāngata whenua - indigenous people
Taonga Puoho - traditional musical instruments
Tauira - student
Teina - junior, younger boy to a brother, younger sister to a girl
Te Ao Marama - the world of light
Te Aho tapu - the sacred thread
Te Ātea - the space in front of the Marae, or space
Te Awa Atua - menstruation
Te Awa Tapu - menstruation
Te Mākū - God of moisture/dampness
Te Kerēme - The Claim (Ngāi Tahu Claim)
Te Pō - the night
Te Reo - the language

Te Wai Pounamu - South Island of New Zealand
Te Whare Tapu o te Tāngata - uterus/womb
Te Whare Kōhanga - a temporary birthing shelter
Te Whe - vibration, sound wave
Tikanga - customs
Tika - correct
Tiki - first man created
Tino Rangatiratanga - Chieftainship
Tītī - mutton bird -
Tohi - birthing ritual
Tohu - emblem, sign
Toi ana - rock art
Tohunga/Tohuka - specialist
Tono - pledge
Tua - birthing ritual
Tuahu - altar
Tūhua - obsidian
Tuahu - sacred altar
Tuhituhi o nehera - rock art
Tuara muka - flax cord for tying umbilical cord
Tuakana-Teina -senior-junior model of learning
Tukutuku - decorative lattice work
Tūhua - obsidian flint
Tūpato - cautious
Tukutuku - lattice style artwork
Tūpuna - ancestor
Tūpuna wahine - female ancestor

U

U - breast
Ūkaipō - mother, breastfeeding at night
Uma - breast
Upoko - head

Uri - descendant

W

Wā - time

Wai - water

Waiata - songs

Waiū - breastmilk

Waka - boat/canoe

Waka taua - war boat/canoe

Wānanga - workshop

Whāea - mother

Whakapapa - lineage

Whakairo -carving

Whakamā - shame, embarrass

Whānau - family

Whānaungatanga - relationship

Whakairatanga - conception

Whakanoa - make ordinary, make common

Whakatauki - proverb

Whakawhanaungatanga - form relationships, make a family

Whare - house

Whare Pūrakau – a house of stories or knowledge

Whare tāngata - womb

Whare tapere - entertainment house

Whare Wānanga - a learning house, learning institute

Whāriki - mat

Wheiao - stage just prior to birth

Whenua - land and placenta

Whitau Muka - flax cordage to tie the umbilical cord

Wānanga whitau - flax cordage to tie the umbilical cord

Wai - water

Whāriki - mat

Whānau - family

Whānau whānui - wider/extended whānau

Wānanga - workshop

Whakairo - carving

Whakāro - thought, philosophy

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